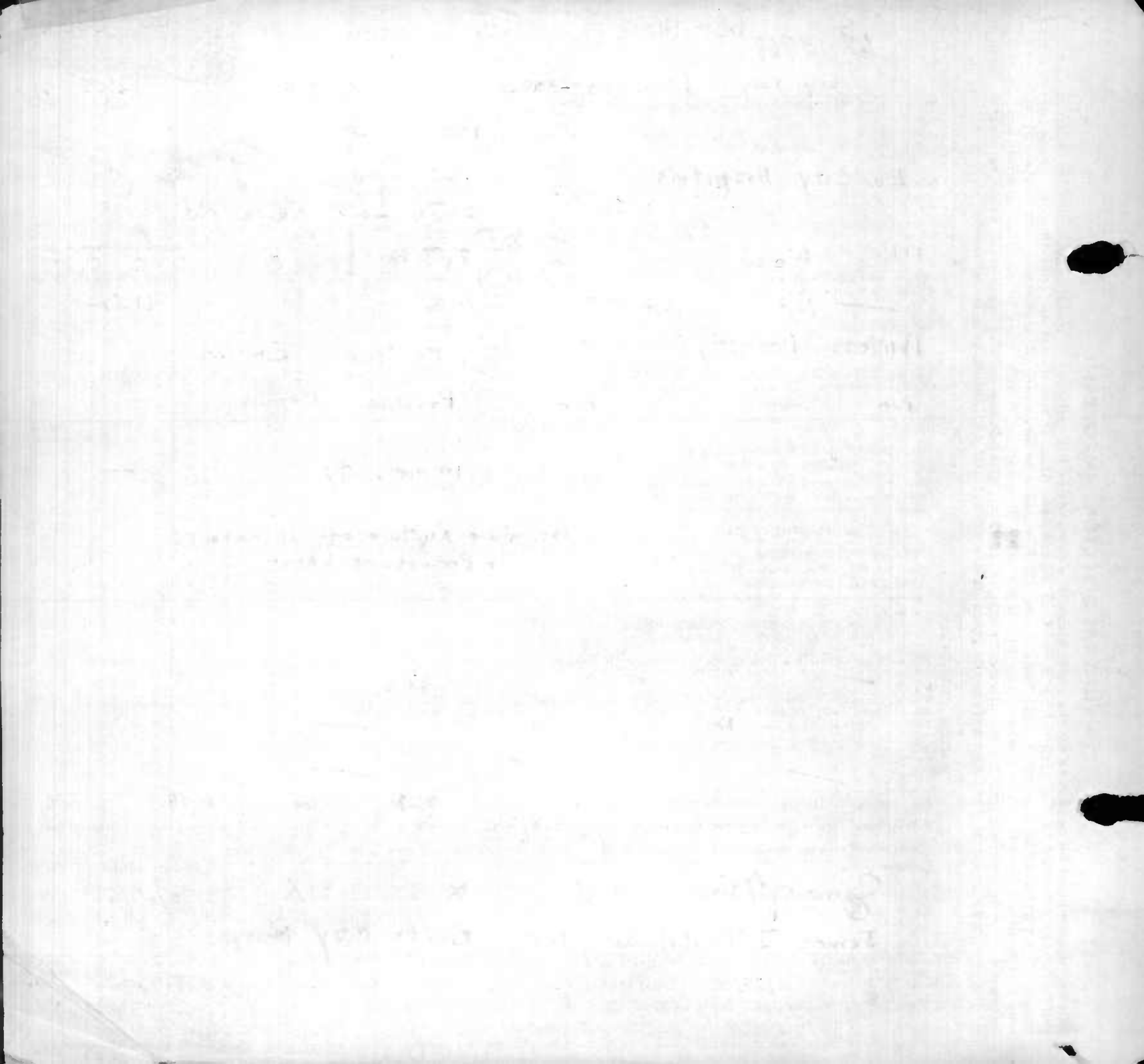


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

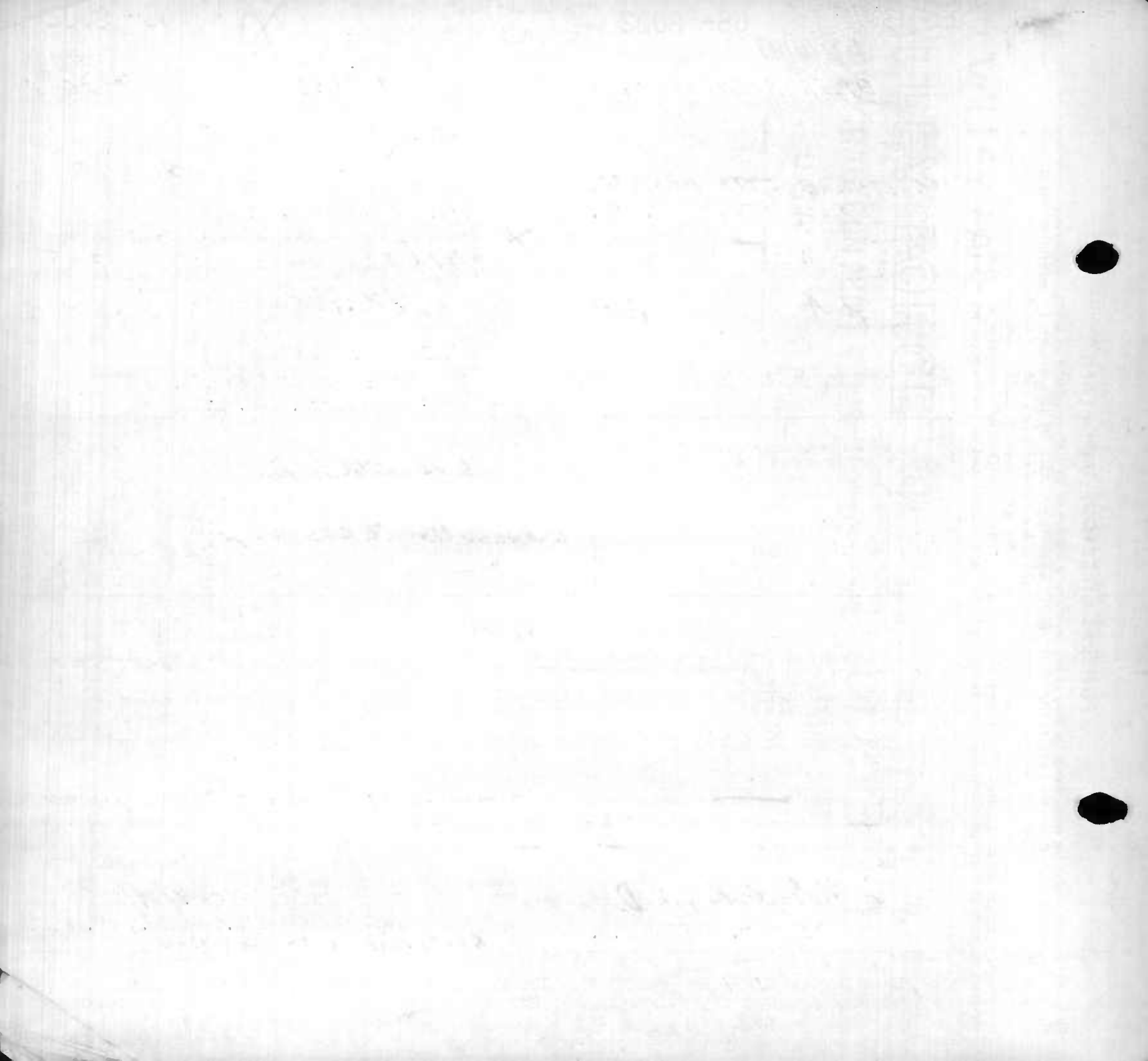
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.		68- 9001 4	
BIRTH NO. <u>68-15968</u>				68- 9001 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Baby Roy Parham -PAULINE</u>				2. DATE AND HOUR OF DEATH <u>8/24/68</u> <u>12:55</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Balto. City Hospitals</u> <u>4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224</u>				A. STATE <u>md.</u> B. COUNTY <u>B</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2404 Loch Raven Rd. 21218</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/68</u>	9. AGE (In years last birthday) <u>0</u>	If Under 1 Yr. Months: <u>0</u> Days: <u>0</u> Hours: <u>0</u> Min. <u>7</u>	If Under 24 Hrs. Min. <u>7</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Printess Doughty</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Brown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NA</u>		17. INFORMANT <u>Pauline Brown</u>			
18. <u>769.1 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Immaturity</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Premature Rupture of membranes + Premature Labor</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>761.5 II</u>							
19A. DATE OF OPERATION <u>8</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> 19 <u>68</u> to <u>8/24</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/24</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>James J. Tabasso, MD</u>				23B. DATE SIGNED <u>8/27/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>James J. TABASSO MD</u>				23D. ADDRESS <u>4940 EASTERN AVENUE, BALTIMORE, MARYLAND</u> <u>Balto. City Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATED</u>		24B. DATE <u>8/29/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE CITY HOSPITALS</u>		24D. LOCATION (City, town, or county) (State) <u>4940 EASTERN AVENUE, BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 4 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabasso</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>68-16191</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68-9002</u>	
1. NAME OF DECEASED (Type or Print) <u>EDLER, BABY GUY, LINDA JEAN</u>			2. DATE AND HOUR OF DEATH <u>8/28/68</u> <u>4:36 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITAL</u> <u>4940 EASTERN AVENUE, BALTO., MD. 21224</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>7701 BRADDOCK AVE. 21224</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/68</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NA</u>	11. BIRTHPLACE (State or foreign country) <u>Balt., MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <u>LINDA JEAN EDLER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>BCH: 4940 EASTERN AVE. BALTO., MD. 21224</u>		ADDRESS
18. <u>772.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Stroke - cerebral anoxia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Unknown (Possible C.V.S. damage)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>NA</u>		
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>YES</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2:45 AM 8/28</u> 19 <u>68</u> to <u>4:36 AM 8/28</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4:30 AM 8/28</u> 19 <u>68</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. M. English, M.D.</u>			23B. DATE SIGNED <u>8/28/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH M. ENGLISH M.D.</u>			23D. ADDRESS <u>4940 EASTERN AVE., BALTO., MD. 21224</u> <u>BALTIMORE CITY HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATED</u>	24B. DATE <u>8/29/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE CITY HOSPITALS</u>		24D. LOCATION (City, town, or county) (State) <u>4940 EASTERN AVENUE, BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 4 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	



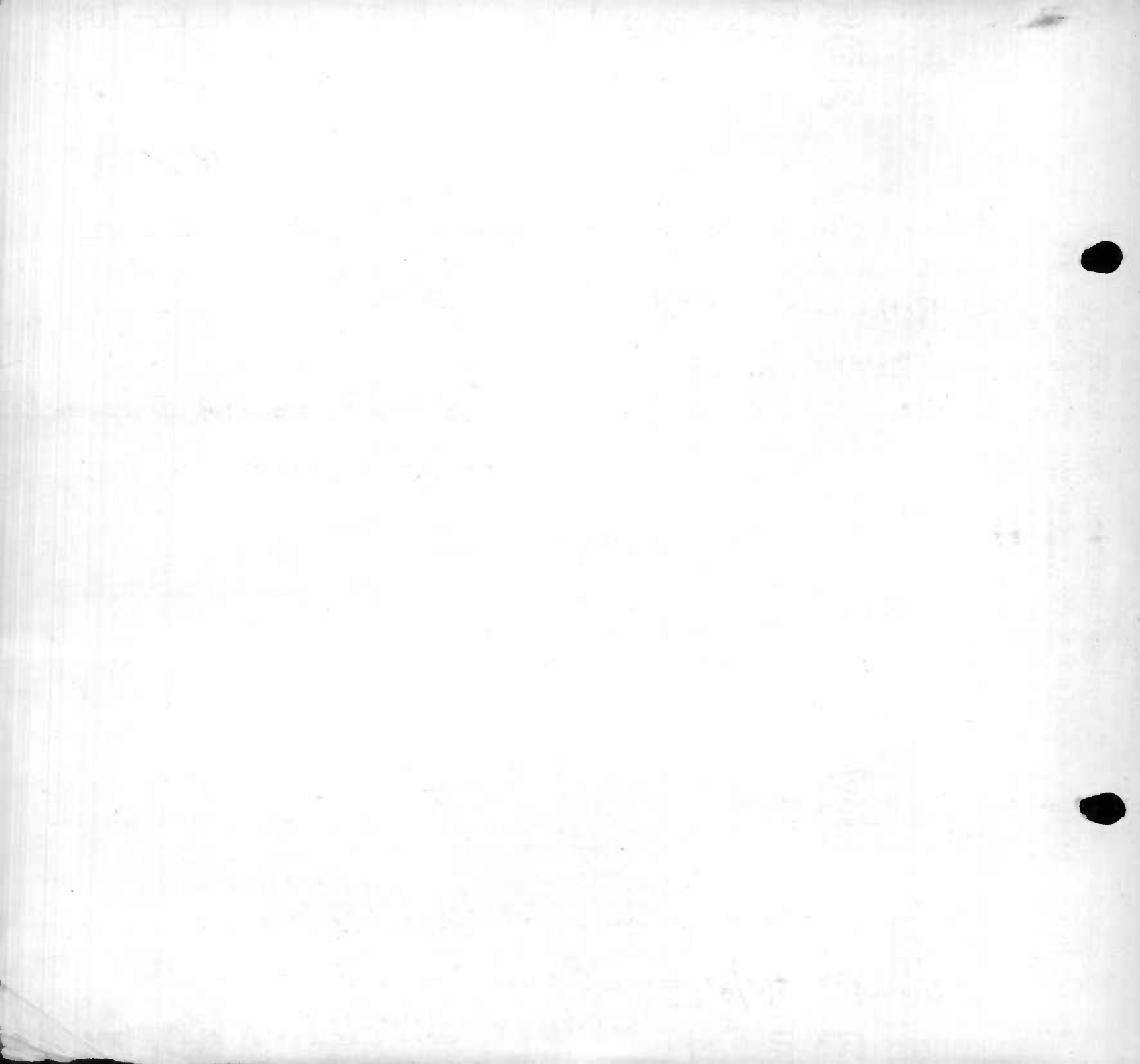
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9003 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9003

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Dimitrios Kollatos		2. DATE AND HOUR OF DEATH August 30/68 10:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 90 MOUNT CONVALESCENT HOME 3706 NORTONIA ROAD			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3706 NORTONIA ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) GREECE	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT George Panos 6607 Old Hartford Rd., Baltimore Md.	
18. 7339 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 332X II			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 15, 1965 to Aug. 30, 1968 , that (I) (we) last saw the deceased alive on Aug. 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz M.D. DEGREE				23B. DATE SIGNED Aug. 31, 1968	
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ, M.D. DEGREE				23D. ADDRESS 7501 Liberty Road, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/3/68		24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Nicholas T. Matthews 3021 Eastern Ave., Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9004	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
E. STREET AND NUMBER					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
ANTÉCEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Extremely Hogenous obesity			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from Sep 2 19 65 to Sep 3 19 65, that (I) (we) last saw the deceased alive on Sep 3 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9005

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MELVIN

BURLEY

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

September 2, 1968

2:54 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 SOUTH BALTIMORE GENERAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 2, 1968

2:54 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY6. SEX
Male7. RACE
NegroB. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
BaltimoreD. INSIDE CITY LIMITS?
YES ☐ NO ☒

9. DATE OF BIRTH

3/9/39

10. AGE (In years
last birthday) 29If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1802 Saratoga Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William Burley

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Viola Jefferson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
no17. SOCIAL
SECURITY NO.

218-36-7569

18. INFORMANT

Mary E. Burley

ADDRESS

703 W. Barre St.

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of Abdomen

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Chesapeake Avenue and Remley Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) Sept. 1, 1968 7:15 P.M.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during altercation

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 2, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/6/68

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 4 1968

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

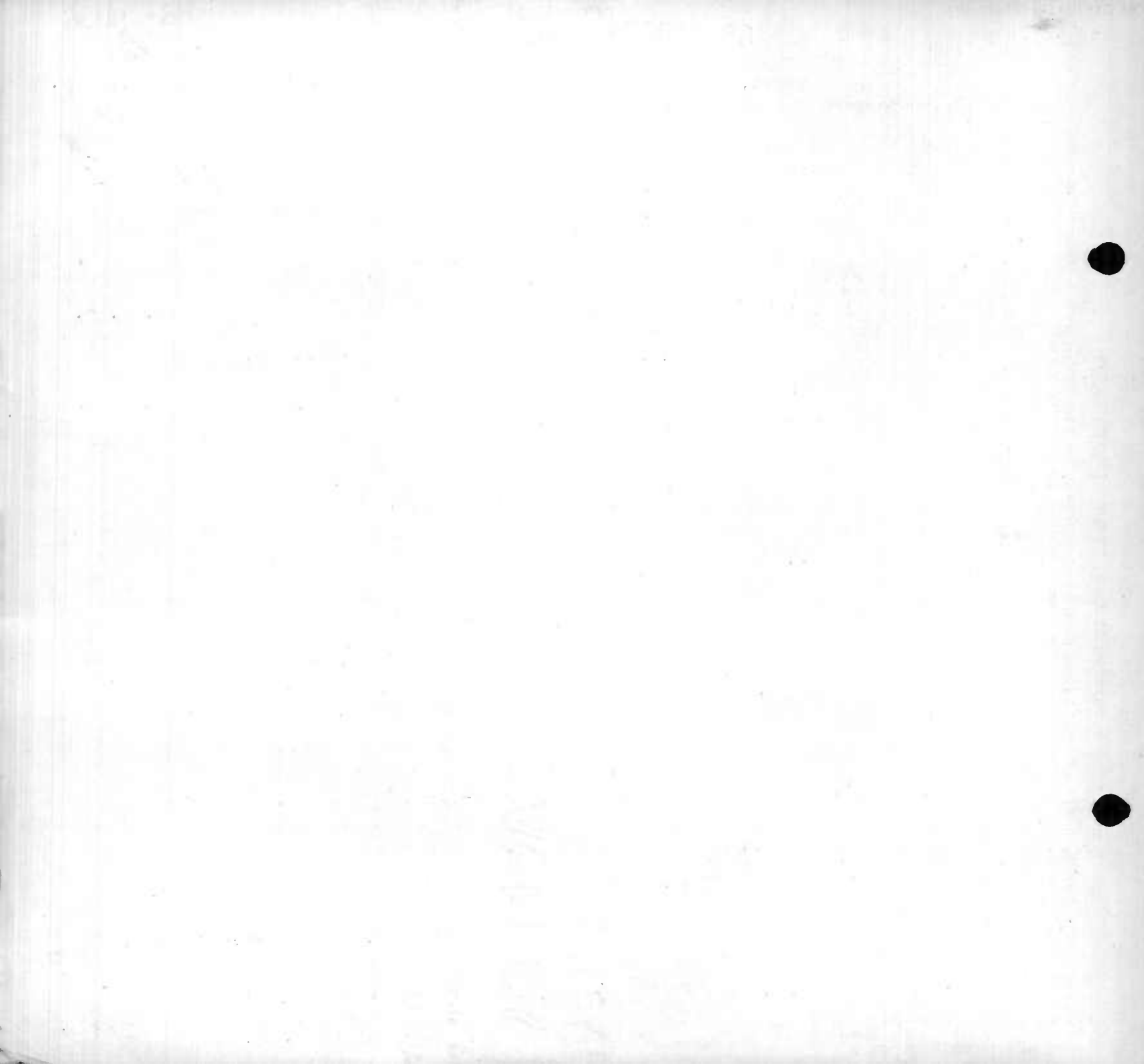
68- 9006 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9006

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Stewart, Marie		8-31-68 5:30 p. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland				A. STATE Maryland B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? 14-03	
				E. STREET AND NUMBER 2029 Madison Avenue	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-02	9. AGE (In years lost birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. MOTHER'S MAIDEN NAME Sarah Harrison					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Theresa Mayfair (Daughter)	
				ADDRESS 3111 Clifton Ave.	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH C.V.A. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-31-68 19 to 8-31-68 19, that (I) (we) last saw the deceased alive on 8-31-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mahoney, M.D.</i> DEGREE				23B. DATE SIGNED 9-3-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS Provident Hospital 1514 Division Street - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-6-68		Mt. Auburn Cem.	
24D. LOCATION (City, town, or county)		24E. STATE			
Baltimore		Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 4 1968		Robert E. Johnson		Elroy O. Wilson	
				ADDRESS Staff	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

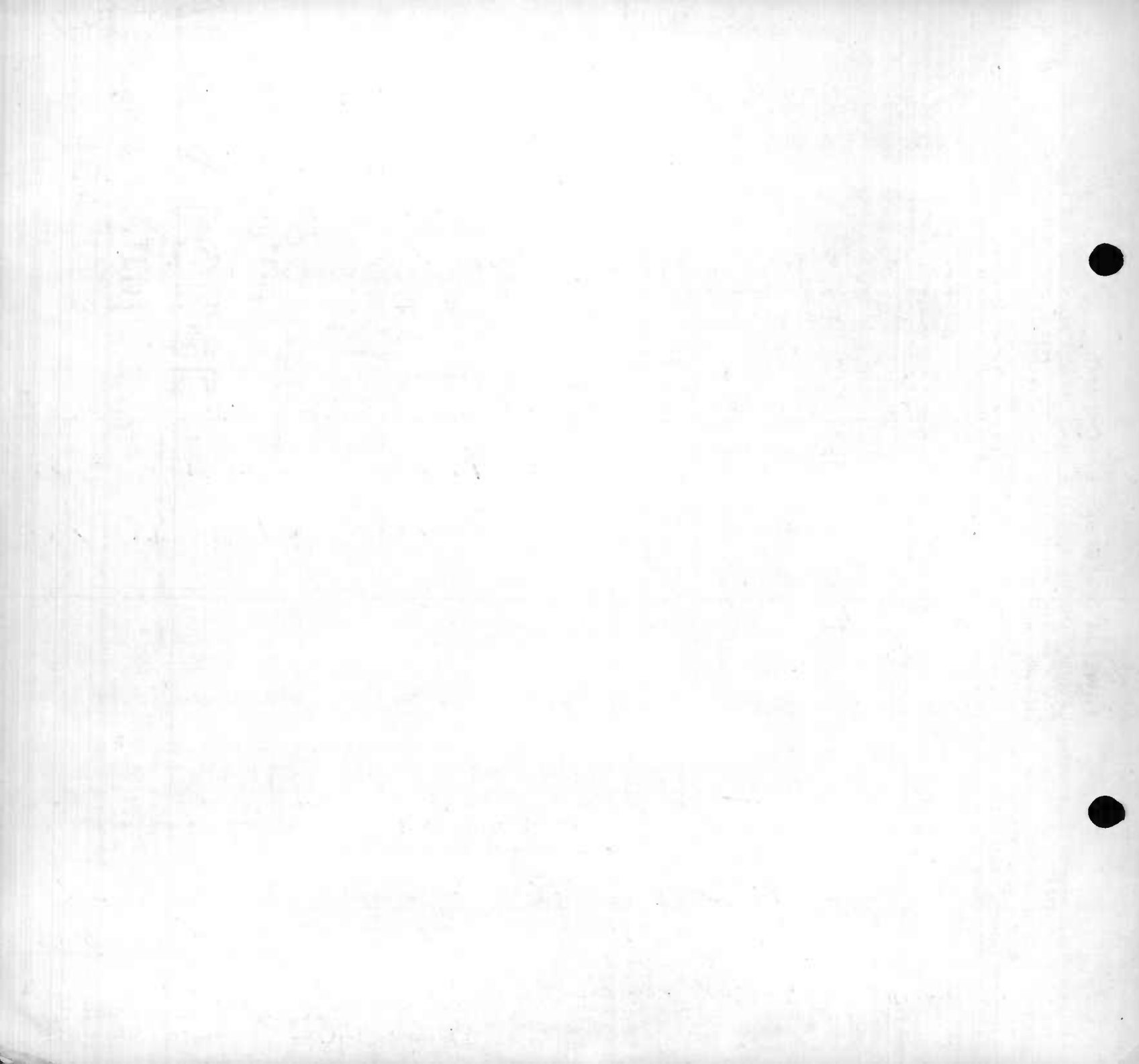
68- 9007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9007

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Randolph Lucas</i>		2. DATE AND HOUR OF DEATH <i>Aug. 30, 1968 6 A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00422 W. May St.</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>1422 W. May St.</i>					
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 2, 1916</i>	9. AGE (In years last birthday) <i>52</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
13. FATHER'S NAME <i>Grover Cleveland Sr.</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW II</i>		16. SOCIAL SECURITY NO. <i>245-05-6262</i>		17. INFORMANT <i>Ida ATKINSON</i>	
				ADDRESS <i>2401 Division St.</i>	
19. <i>01115 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Bronchial pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Active Pulmonary tuberculosis 8 yrs-</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 Days</i>		
MEDICAL CERTIFICATION <i>0021 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>0</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-18-1961</i> to <i>8-30-1968</i> , that (I) (we) last saw the deceased alive on <i>6-14-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Eugene H. Owens MD</i> DEGREE				23B. DATE SIGNED <i>9-3-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Eugene H. Owens</i> DEGREE				23D. ADDRESS <i>1735 E. Federal Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-5-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Hope Baptist Cem.</i>	
				24D. LOCATION (City, town, or county) (State) <i>Washington N. Carolina</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 4 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles O. Wilson</i>	
				ADDRESS <i>10008 Bentley Ave. N.C.</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9008

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES CARLO		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> August 28, 1968 3:07 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 28, 1968 3:07 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6031	
9. DATE OF BIRTH Feb 9, 1908		10. AGE (In years lost birthday) 60 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Thurmond Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Carlo		14. MOTHER'S MAIDEN NAME Anna	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rent man - Sanitary Laundry		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —		17. SOCIAL SECURITY NO. 217-09-0696	
18. INFORMANT Orlena Carlo		ADDRESS 5030 - E. Be. St.	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 29, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 2/68	
24C. NAME OF CEMETERY or CREMATORY Mt Carmel		24D. LOCATION (City, town, or county) (State) 5712 Herman Hill Rd. Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 4 1968		25B. NAME OF REGISTRAR Robert E. Fajana	
25C. FUNERAL DIRECTOR T. Fisher - 1930 Eastern Ave.		ADDRESS	

100-3

100-3

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9009

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Tillie Szlachetka

2. DATE AND HOUR OF DEATH

Aug. 29, 1968

4:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

90

1105 E. Fayette Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

53-00

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

369 Choptank Ave.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Mar 3, 1884

9. AGE (In years
last birthday)

84

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John

14. MOTHER'S MAIDEN NAME

Mathilda Szlachetka

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Francis Griffith 1212 Sargent S

18. **445.0 I**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Cardiac Dilatation

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Vascular Disease

(C)

DUE TO, OR AS A CONSEQUENCE OF:

Compromised Left Leg

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7 yrs.

MEDICAL CERTIFICATION

450.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Nat White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~XXXXXX~~ attended the deceased from **Aug. 29 1968** to **Aug. 29 1968**,
that (I) ~~XXXX~~ saw the deceased alive on **Aug. 29, 19 68** and that in (my) ~~XX~~ opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. William G. Geyer

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

8/29/68

23C. PHYSICIAN'S
NAME (Type)

William Geyer

MD

DEGREE

156 N. Milton Ave

24A. BURIAL CREMATION
REMOVAL (Specify)

24B. DATE

9/3/68

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart Cem German Hill Rd.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

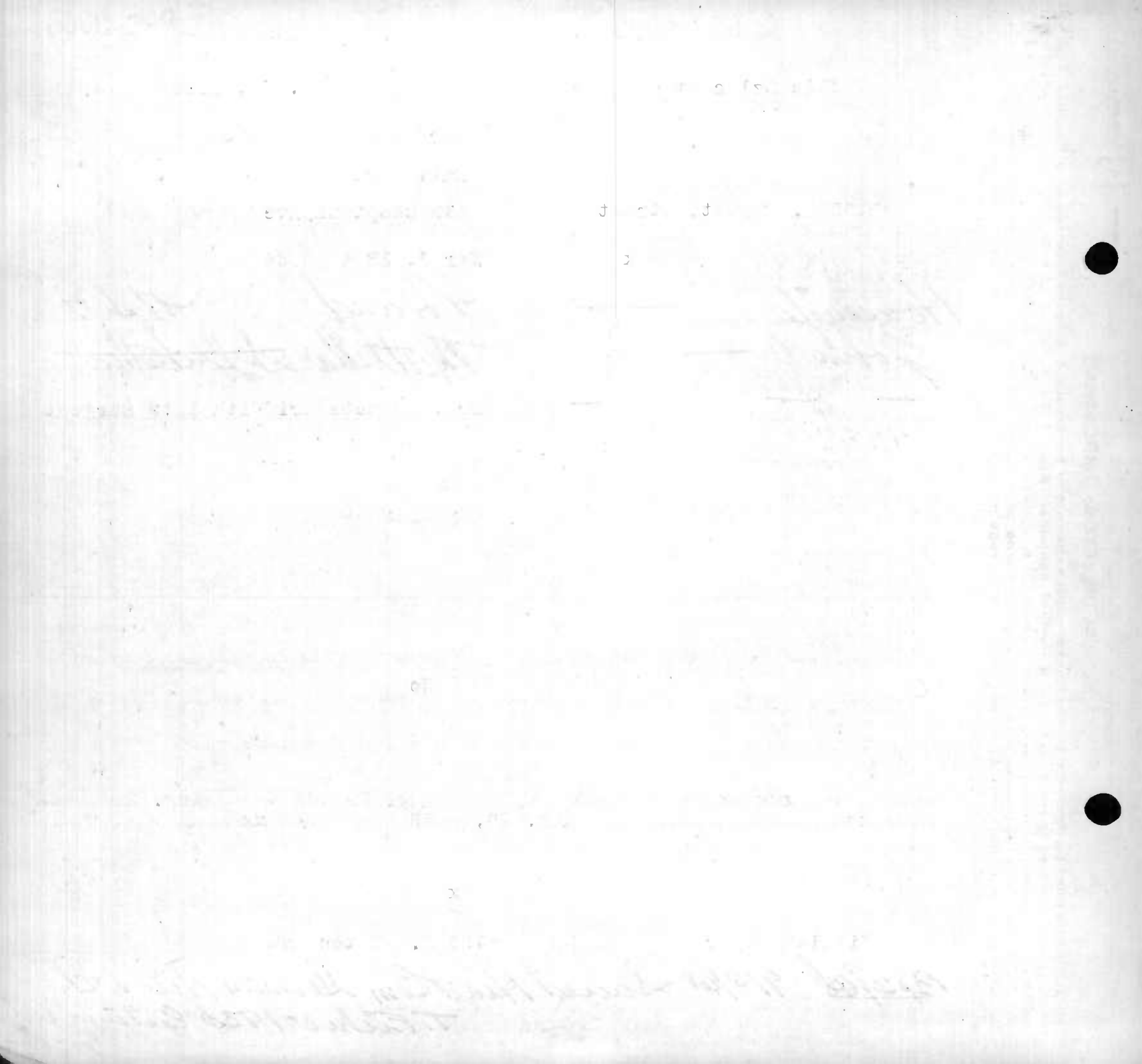
SEP 4 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

T. Fisher - 1930 Eastern Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9010

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 9010

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		KUNKEL, JOHN Aloysius JR.		9/1/68 3:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL				A. STATE B. COUNTY MD. BALTIMORE 53-00	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS? OWINGS Mills YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 11026 REISTERSTOWN Rd	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday)
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DEC. 31/1934		33
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Painter		Andrews Building Co.		Harrison, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John A. Kunkel, Sr.			Goldie Levine Redman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give branch and service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		Korea Since 1955		HOSP RECORDS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				1 week	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				1-2 years	
(B) Hepatic Coma & GI bleeding					
(C) Nutritional Cirrhosis					
581.0 II				many years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
Idiopathic epilepsy					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/23 19 68 to 9/1 19 68, that (I) (we) last saw the deceased alive on 9/1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Howard R. Friedman M.D.				9/1/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
HOWARD R. FRIEDMAN M.D.				Sinai Hospital of Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/5/68		Baltimore National Cemetery, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 11 1968		Robert E. Sisk		Frank H. Newell, Baltimore, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9011 CERTIFICATE OF DEATH

REG. NO. 68- 9011

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MANSFIELD, ETHEL IRENE

2. DATE AND HOUR OF DEATH

8-30-68

12:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSP.

WILKENS & CATON - BALTO.MD.21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

RANDALLSTOWN, MD

21133 B & C

C. CITY OR TOWN

RANDALLSTOWN

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

22 MILLSTONE RD.

53-00

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

06-08-00

9. AGE (In years last birthday)

68

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

THOMAS J. GROOMES

DEC'D

14. MOTHER'S MAIDEN NAME

REBECCA C. (

) DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

219-22-5607-D

17. INFORMANT

ADDRESS

ST. AGNES RECORDS - WILKENS & CATON

18. 456.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

massive hemorrhage

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Ruptured esophageal varices

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 8-24-68 to 8-30 19 68, that (X) (we) last saw the deceased alive on 8-30 19 68 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (XX) (did not) view the body after death.

23A. SIGNATURE

Amestacia S. Johns

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/30/68

23C. PHYSICIAN'S NAME (Type)

ANASTACIA E. FABIE

23D. ADDRESS

ST. AGNES HOSPITAL ; WALKENS & CATON

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT

SEP 1 1968

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

B-500

68- 9012

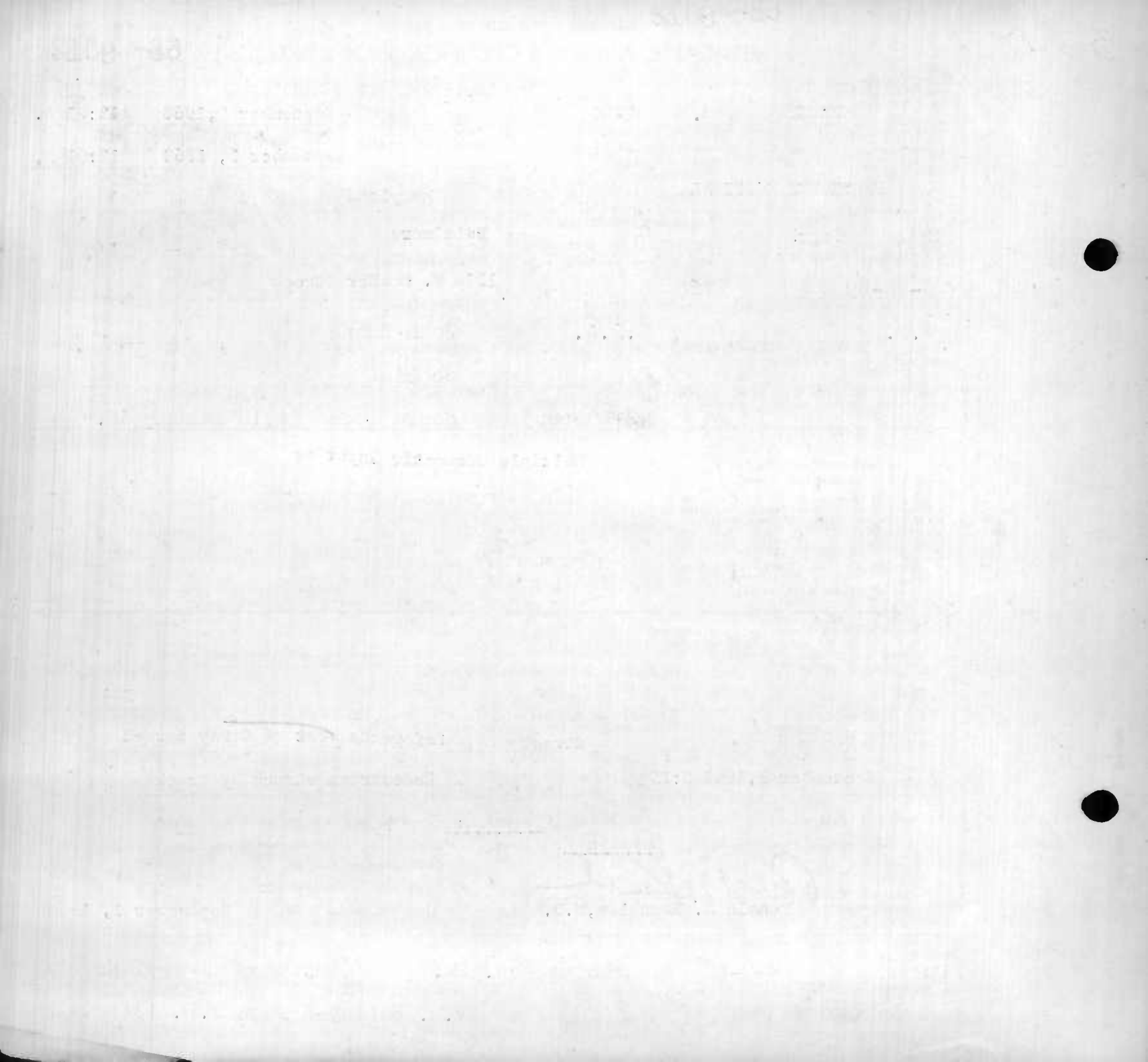
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9012

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SWEENEY D. BOONE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 2, 1968 12:01 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 2, 1968 12:01 A.M.	
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-16-89		10. AGE (In years lost birthday) 78 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 212095865	
18. INFORMANT Caldonia Boone		ADDRESS 1310 Mosher St.	
19. 2814.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) September 1, 1968 8:15		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Lafayette West of Carey Street	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by truck	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-68	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Arbutus Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 4 1968		25B. NAME OF REGISTRAR Robert E. Farber	
		25C. FUNERAL DIRECTOR V.R. Bailey-Kelson	
		ADDRESS F.H. 1348 Calhoun	



FUNERAL DIRECTOR: IMPORTANT

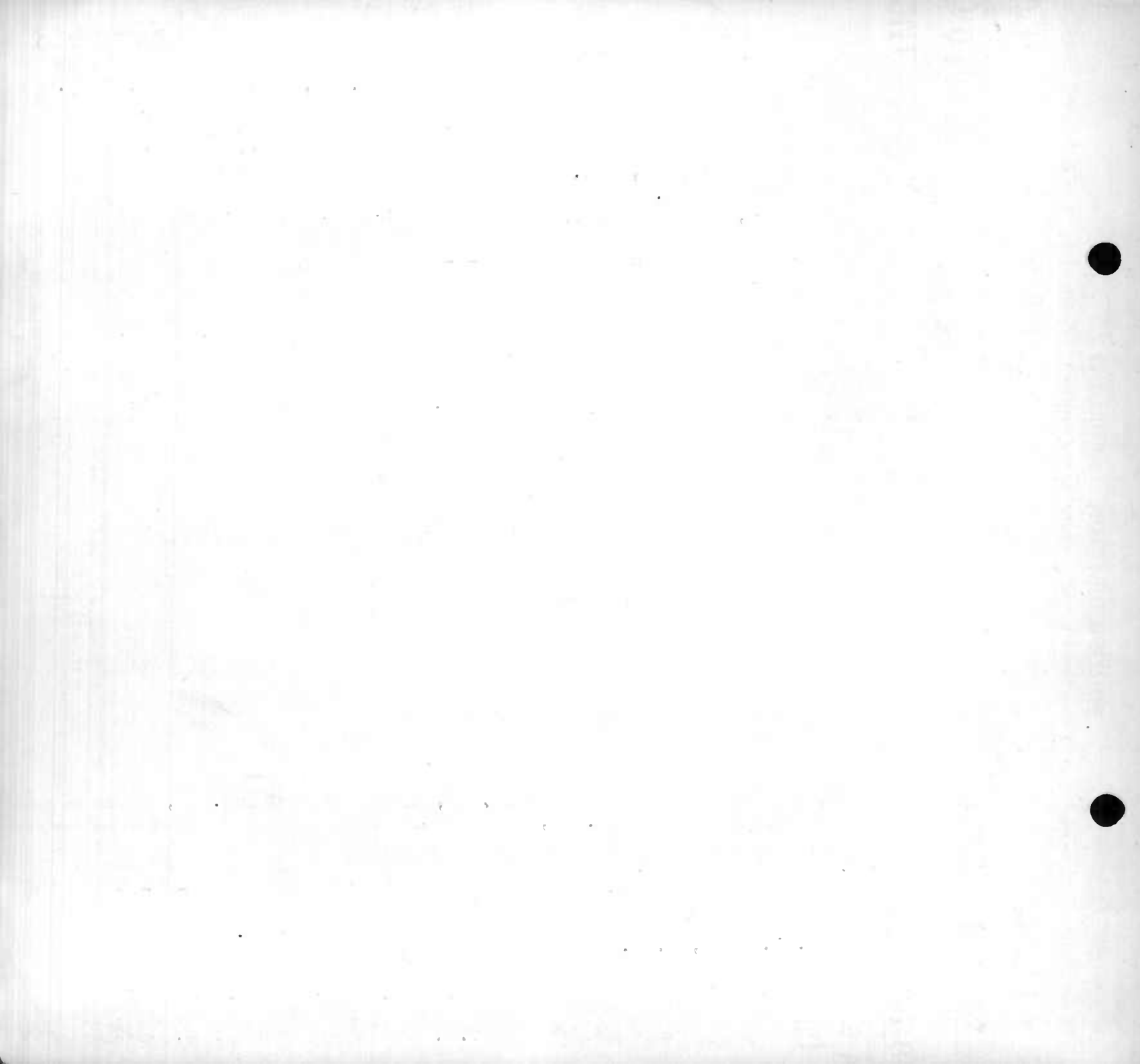
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9013 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9013

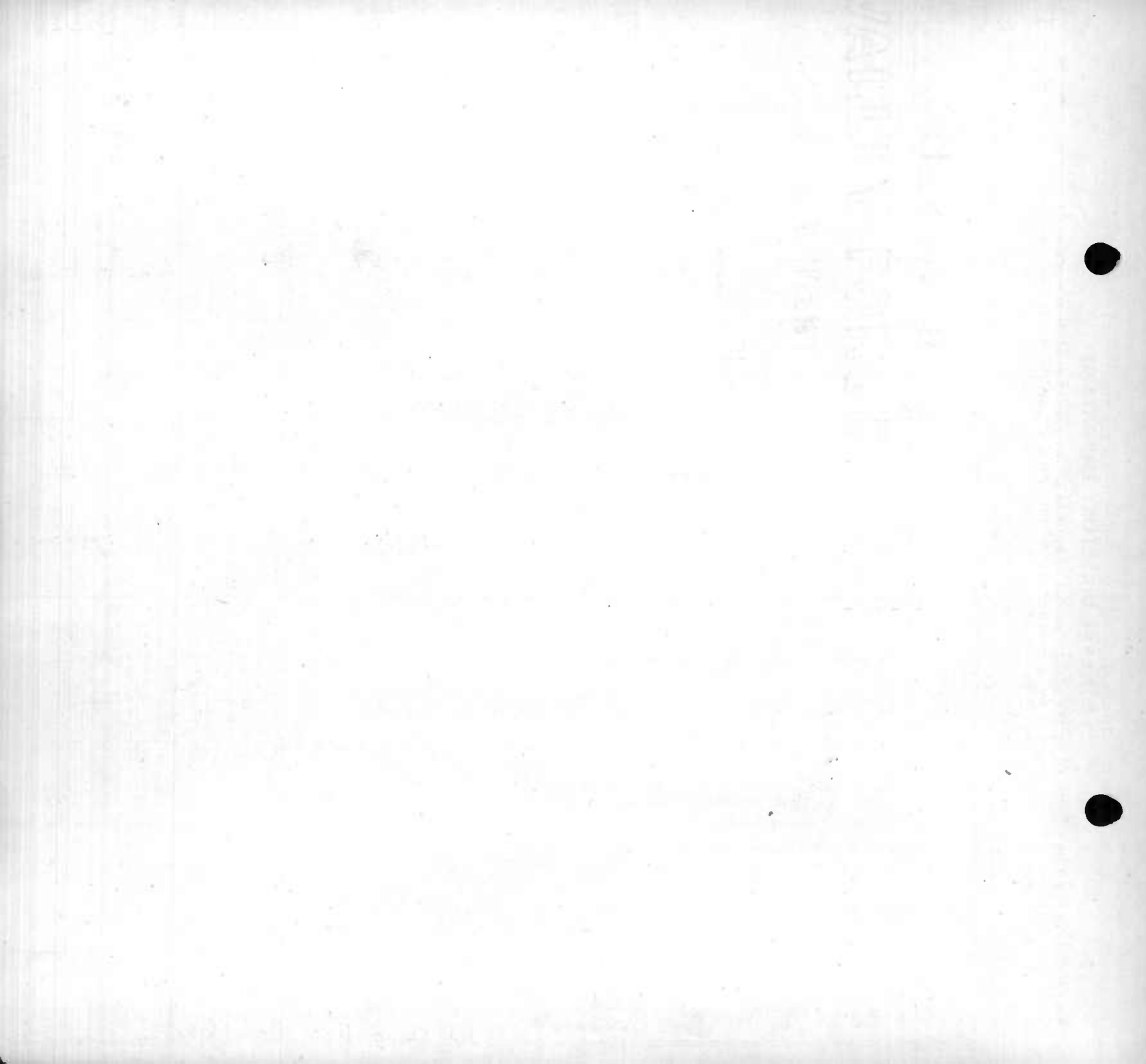
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Paul Cleveland		Aug. 30, 1968 6:45 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 452 Oxford Court	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-81	9. AGE (In years lost birthday) 87	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Jordan Cleveland			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217094087		17. INFORMANT Mrs. Alice Berkley (Neice) Virginia	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 286.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF dehydration?					
(B) dehydration, malnutrition DUE TO, OR AS A CONSEQUENCE OF:					
(C).....					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 29, 1968 19 to Aug. 30, 1968 19, that (I) (we) last saw the deceased alive on Aug. 30, 1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. J. Kook, M. D.				23B. DATE SIGNED 8-31-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
M. J. Kook, M. D.		1514 Division St.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation	9-3-68	Loudon Park Nat'l. Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 4 1968		Robert E. Folsom		V.R. Bailey-Kelson F. H. 1348 Calhoun	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9014	
BIRTH NO. 68- 9014		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NELSON MRS. META J.			2. DATE AND HOUR OF DEATH September 2, 1968 10:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bow Secours Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2323 Calverton Heights Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-09-29	9. AGE (In years last birthday) 39	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Boston			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-27-1687	17. INFORMANT Husband - CHART		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 330 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Subarachnoid + intracerebral hemorrhage, base of brain. (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day year		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 330 X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-1-1968 to 9-2-1968, that (I) (we) last saw the deceased alive on 9-2-1963 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Martinez			23B. DATE SIGNED 9-2-68		23C. PHYSICIAN'S NAME (Type) S. Martinez
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-6-68		24C. NAME OF CEMETERY or CREMATORY Bolto. Nat'l. Cem.
24D. LOCATION Bolto. Md.			24E. ADDRESS 2025 W. Fayette St. BALTO, MD 21223		
25A. DATE REC'D BY HEALTH DEPT. SEP 4 1968		25B. NAME OF REGISTRAR Philip E. Taylor		25C. FUNERAL DIRECTOR V.R. Bailey-Nelson F.H.	
25D. ADDRESS 1348 Calhoun St.					

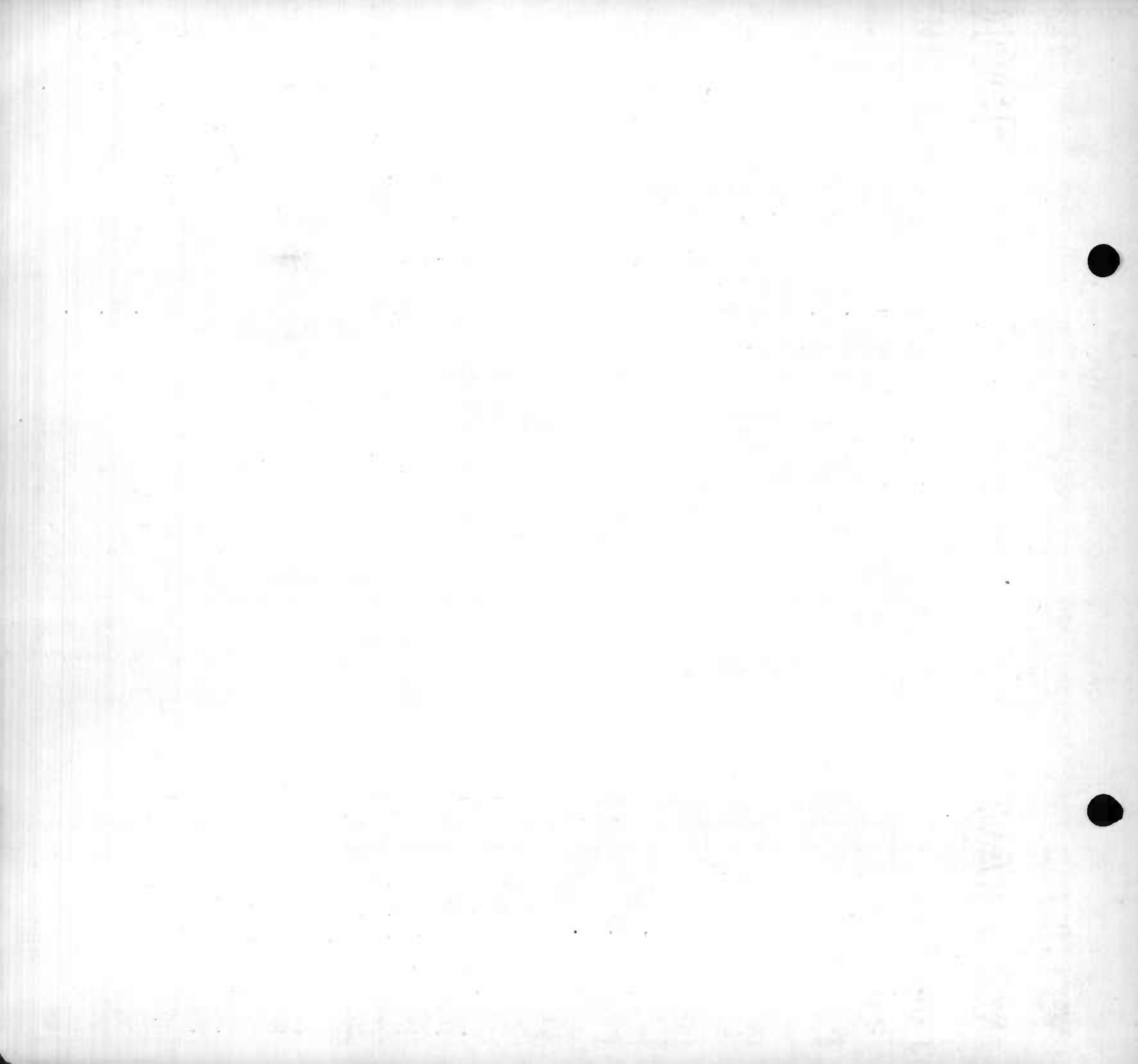


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9015 CERTIFICATE OF DEATH

REG. NO. 68- 9015

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Stevenson, Margaret		2. DATE AND HOUR OF DEATH 8-31-68 11:15 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2130 Division Street	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-1881	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None- U. S. Government		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Swanson		14. MOTHER'S MAIDEN NAME Margaret Sears	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret Wakins (Daughter)	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular Accident (B) Any Arteriosclerotic of Left Leg DUE TO OR AS A CONSEQUENCE OF: Generalized Arteriosclerosis (C) Generalized Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-15-68 at 2:10 A.M. 8-31-68 at 11:15 P.M.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-15-68 19 to 8-31-68 19, that (I) (we) last saw the deceased alive on 8-31-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymundo Corpuz, M.D.				23B. DATE SIGNED 9-3-68	
23C. PHYSICIAN'S NAME (Type) Raymundo Corpuz, M. D.		23D. ADDRESS Provident Hospital 1514 Division Street - Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-5-68		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.			
25A. DATE REC'D BY HEALTH DEPT. SEP 4 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR V.R. Bailey	
25D. ADDRESS 1348 Calhoun		25E. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9016

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Billups, Helen		2. DATE AND HOUR OF DEATH 8-31-68 9:08 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4726 Wakefield Road		39	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-06	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Terrill		14. MOTHER'S MAIDEN NAME Emma Laws	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 130262235		17. INFORMANT Mrs. Gloria Ruff (Daughter)	
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) Hypertensive arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C)		19. DATE OF OPERATION 0		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8-23-68 19 to 8-31-68 19, that (I) (we) last saw the deceased alive on 8-31-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Humberto Certeza	
23B. DATE SIGNED 9-1-68		23C. PHYSICIAN'S NAME (Type) Dr. H. Certeza		23D. ADDRESS Provident Hospital 1514 Division Street - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-4-68		24C. NAME of CEMETERY or CREMATORY Church Cemetery	
24D. LOCATION (City, town, or county) (State) Gloucester Co., Virginia		25A. DATE REC'D BY HEALTH DEPT. SEP 4 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Kelson F.A.		25D. ADDRESS 1348 Calhoun St.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9017	
200		68- 9017		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BOYCE, RUSSELL (James)		SEPT 2 1968 11:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ST AGNES HOSPITAL-CATON & WILKENS BALTO MD 21229		E. STREET AND NUMBER 2555 MADISON AVE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09 08 14	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY FOOD FAIR		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME RANDOLPH BOYCE		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217096174		17. INFORMANT ADDRESS ST AGNES RECORDS-BALTO MD 21229	
18. 43001 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral Coma. DUE TO, OR AS A CONSEQUENCE OF: (B) Subarachnoid Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (C) Possible ruptured Aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 330X II A.S.C.V.D.-Hypertension					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPT 2 1968 to SEPT 2 1968, that (X) (we) last saw the deceased alive on SEPT 2 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <i>Alexandro Mejia</i> DEGREE				23B. DATE SIGNED 09 02 68	
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA MD				23D. ADDRESS ST AGNES HOSP. BALTO MD 21229	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9-7-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 4 1968		24F. NAME OF REGISTRAR R. E. Bailey-Kelson	
24G. FUNERAL DIRECTOR V.R. Bailey-Kelson		24H. ADDRESS F.H. 1348 Calhoun			

RECEIVED

2222 MADISON AVE

88 02 14

MARYLAND

8802 14

RANDOLPH BOYD

2222 MADISON AVE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9018

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAKE

LASSITER

2. DATE
OF
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

September 2, 1968

7:55 P.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 2, 1968

7:55 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

1-7-86

10. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

818 N. Carrollton Avenue

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Further

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Henrietta Lassiter

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Elma Lassiter 818 Carrollton Ave.

19. 412.4 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

BX 9/3/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-7-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 4 1968

25B. NAME OF REGISTRAR

Robert E. Tanaka

25C. FUNERAL DIRECTOR

V.R. Bailey-Kelson F.H. 1348 Calhoun

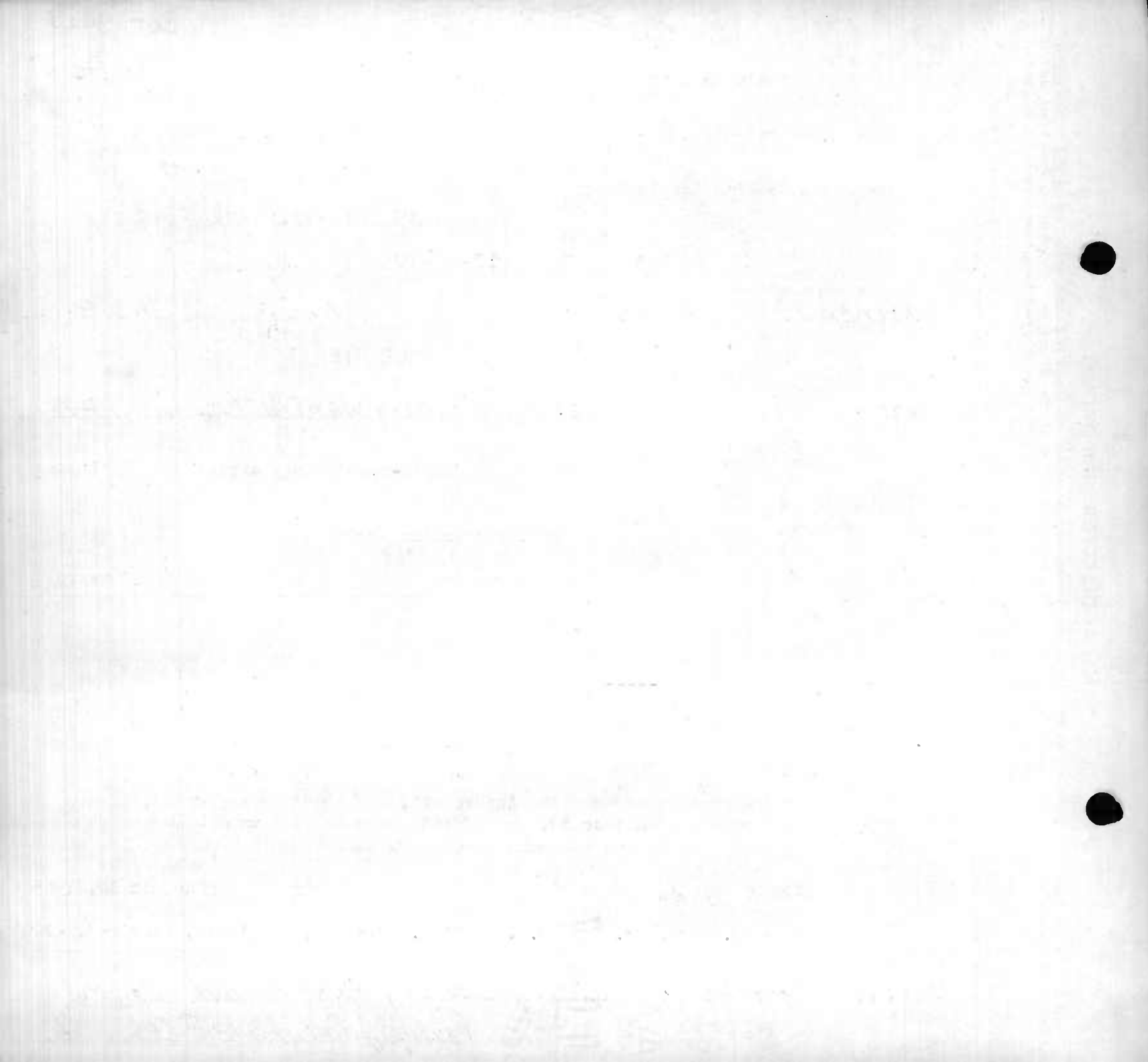
ADDRESS

Received

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9019
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alonzo Taft		August 30, 1968 10:27 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital			A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 1615 CLIFTVIEW AVE 21213		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-10	9. AGE (In years lost birthday) 57	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Lumber Co.		11. BIRTHPLACE (State or foreign country) N. C.	
13. FATHER'S NAME ROBERT TAFT			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 245-20-280		17. INFORMANT Mrs Mary Ward / 1615 Clifview Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: 5 minutes (B) cerebrovascular accident X 3 DUE TO, OR AS A CONSEQUENCE OF: 3 weeks (C) Hypertension 10 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) XXXXX		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) XXXXXX	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) XXXXXXX		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR? XXXXXX	
22. I certify that (I) (this hospital) attended the deceased from August 11, 1968 to August 30, 1968, that (I) (we) last saw the deceased alive on August 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.					
23A. SIGNATURE George H. Sack, Jr. M.D.				23B. DATE SIGNED August 30, 1968	
23C. PHYSICIAN'S NAME (Type) George aH. Sack, Jr.		23D. ADDRESS M.D. 601 N. Broadway, Baltimore, Maryland, 21205			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-4-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 4 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ralph J. Collick 24316 Oliver St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9020 CERTIFICATE OF DEATH

REG. NO. 68- 9020

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDWARDS, JAMES

2. DATE AND HOUR OF DEATH

8/30/68 4:50 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (If deceased lived in institution: residence before admission)
A. STATE B. COUNTY

MARYLAND BALTIMORE CITY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE
E. STREET AND NUMBER

8 YES ☒ NO ☐

271 EAST BIDDLE STREET

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

3-28-06

9. AGE (In years last birthday)

62

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Oilcr

10B. KIND OF BUSINESS OR INDUSTRY

Oil Stage Co.

11. BIRTHPLACE (State or foreign country)

Smithfield Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WALTER EDWARDS

14. MOTHER'S MAIDEN NAME

MARTHA KEYES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

223-104599

17. INFORMANT

Mrs. Viola J. Edwards

ADDRESS

2700 E. Biddle St.

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

8-10 Hrs.

(B) ASCVD - Hypertension
DUE TO, OR AS A CONSEQUENCE OF:

71 yr.

(C) _____

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐ Work

Not White At ☐ Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 29 11 PM 19 68 to August 30 4:50 AM 19 68, that (I) (we) last saw the deceased alive on August 30 4 PM 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

E. D. Hank Jr. M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

Intern ☒

23B. DATE SIGNED

8/30/68

23C. PHYSICIAN'S NAME (Type)

EDWARD D. HANK JR M.D.

DEGREE

23D. ADDRESS

1519 E. MONUMENT STREET, BALTIMORE, Md. 21205

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

9-2-68

24C. NAME of CEMETERY or CREMATORY

?

24D. LOCATION

Smithfield, Va.

(City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

SEP 4 1968

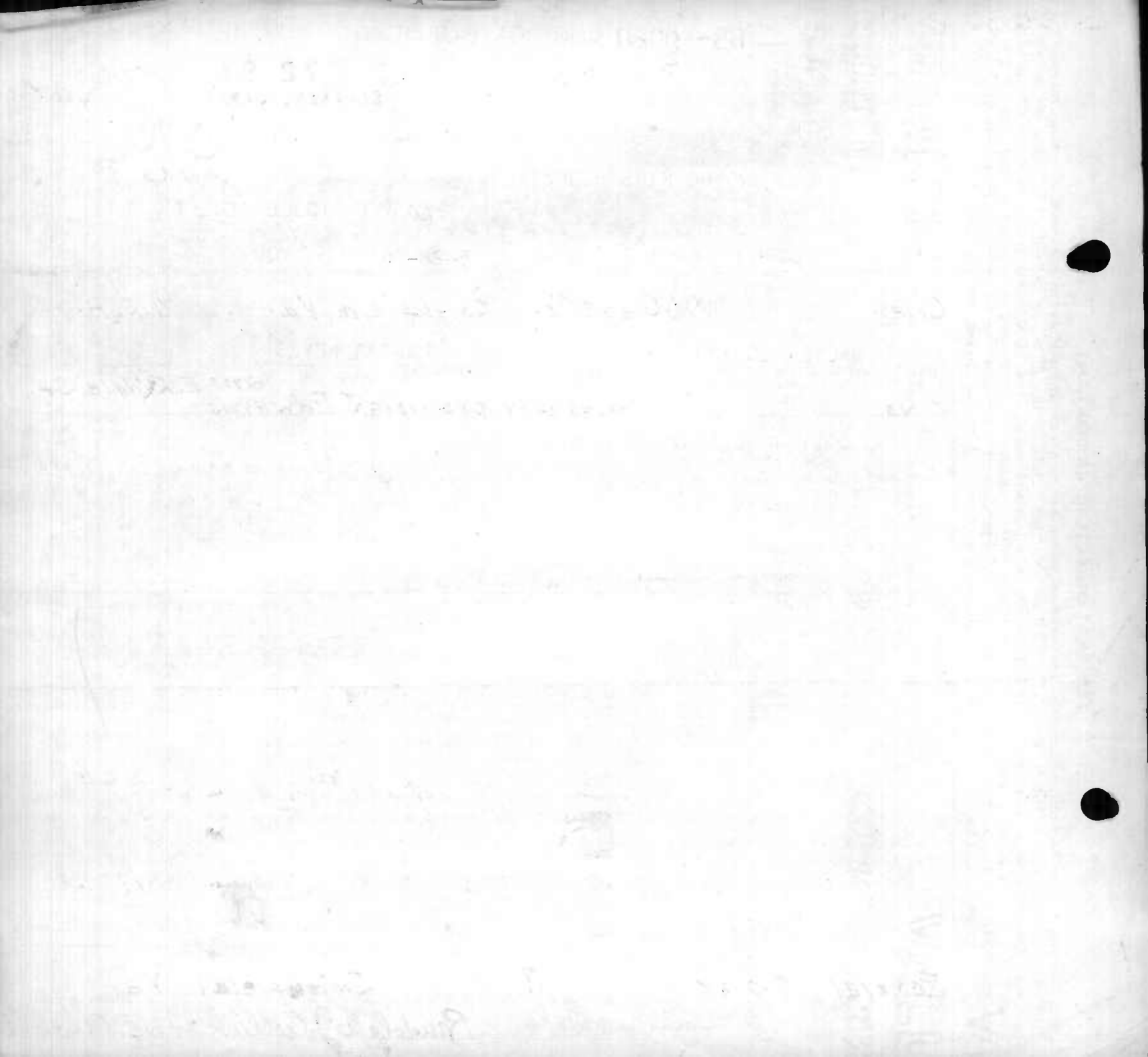
25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Rudolph J. Collick 2431 E. Oliver St.

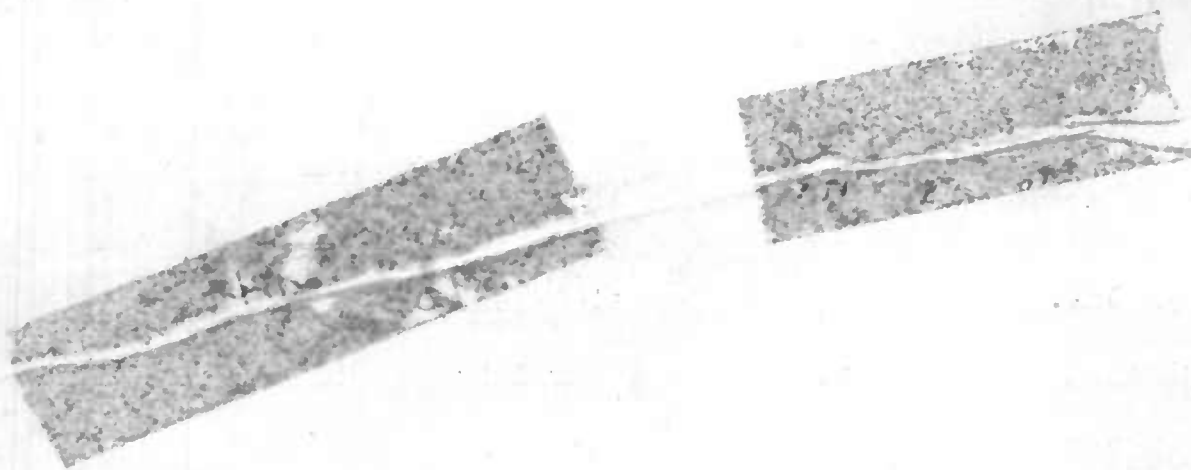
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9021
68- 9021		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) HAYNIE, Louise		2. DATE AND HOUR OF DEATH 8-31-68 3-35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital At Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 15-11 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3520 Hilton Rd.		
5. SEX Female	6. RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 93 9. AGE (In years, lost birthday) 74 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unkown		14. MOTHER'S MAIDEN NAME Amanda Jones		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Gertrude Brooks ADDRESS
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Ascv.D Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ascv.D and cerebral arteriosclerosis				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8-19-1968 to 8-31-1968 , that (I) (we) last saw the deceased alive on 8-31-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. Baig		23B. DATE SIGNED 8-31-68		
23C. PHYSICIAN'S NAME (Type) J. Baig		23D. ADDRESS 1913 W. Balto. St		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 3, 68		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) Baltimore		(State) Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 4 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR'S NAME Stetson D. Wilson



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED - 9/1/68

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. 68- 9022
BIRTH NO. 68- 9022						
1. NAME OF DECEASED (Type or Print) Walter E. Alston			2. DATE AND HOUR OF DEATH 10/2/68 9/2/68 8 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident H ospital 1514 Divison St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
5. SEX Male			6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10/5/1894			9. AGE (In years last birthday) 73		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special Delivery Mess.			10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph Alston			
14. MOTHER'S MAIDEN NAME Carrie J. Eaton			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216-44-2889			17. INFORMANT Mrs Elizabeth Alston 521 Bloom St.			
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of colon with ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. extensive metastasis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 153.8 II						
19A. DATE OF OPERATION 18/6/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of colon		20A. AUTOPSY? (Yes or No) NO		
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 29 1968 to Sept 2 1968 , that (I) (we) last saw the deceased alive on Sept 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Bernard Harris Jr. M.D.				23B. DATE SIGNED Sept. 4, 1968		
23C. PHYSICIAN'S NAME (Type) Bernard Harris Jr. M.D.				23D. ADDRESS 1200 McCulloh St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/1/68		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		
24D. LOCATION Baltimore, CO. Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 4 1968				
25A. NAME OF REGISTRAR Robert E. Feltman		25B. FUNERAL DIRECTOR Herbert E. Nutter		25C. ADDRESS 3035 W. North Ave.		

9/17/68 - Letter from Prividant Hospital dated Sept. 17, 1968. Signed by
Phyllis Brown, Medical Record Librarian. Walton Alston expired
Sept. 2, 1968. Correction form from funeral director - re:
date of burial. *ABC*

FUNERAL DIRECTOR: IMPORTANT

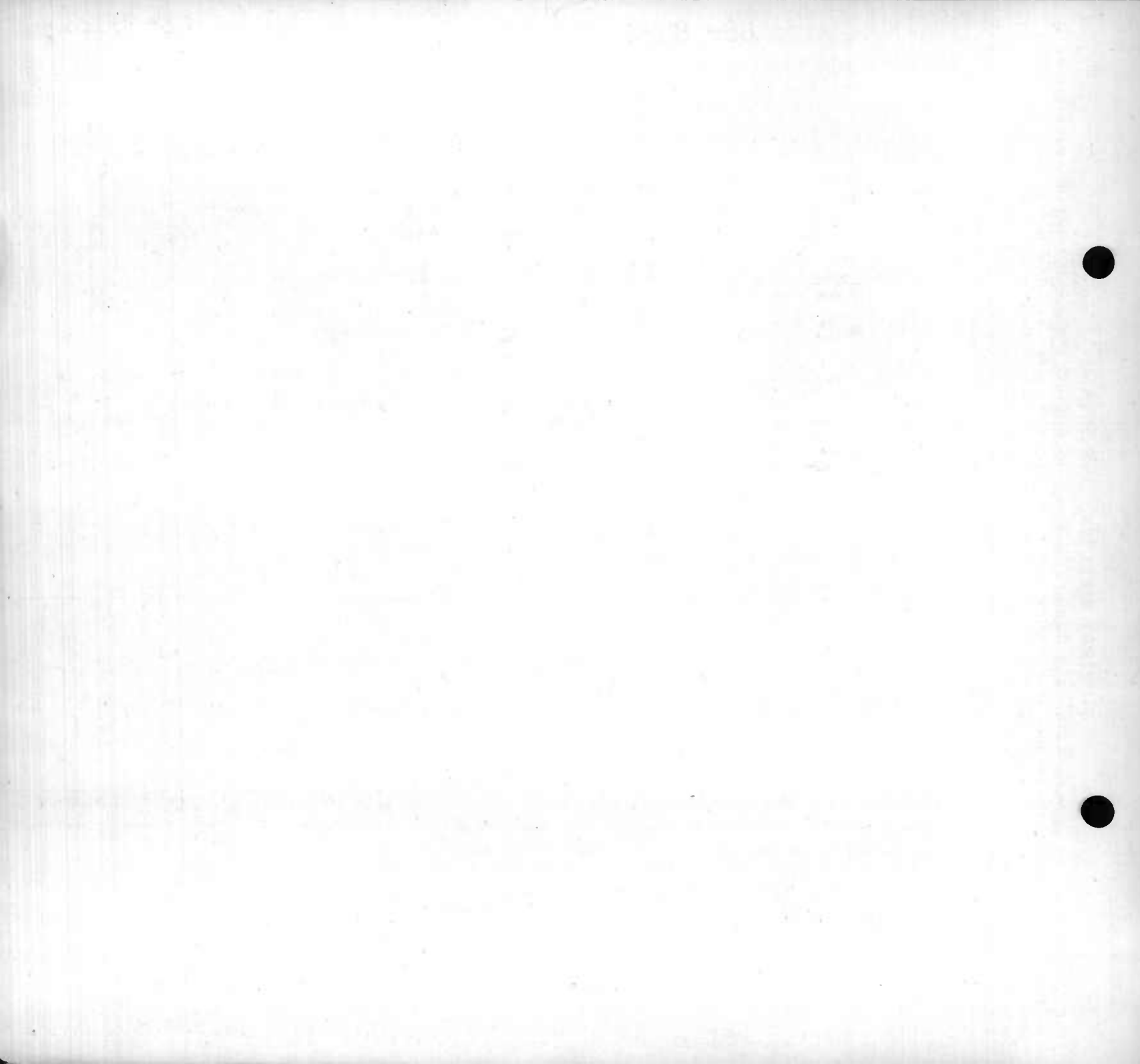
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68- 9023

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>BARNETT, Mrs. Mollie</i>		2. DATE AND HOUR OF DEATH <i>8-23-68 4:20 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>15-11</i>		C. CITY OR TOWN <i>BALTIMORE 21215</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>		E. STREET AND NUMBER <i>3202 SEQUOIA AVENUE</i>			
5. SEX <i>FE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-12-78</i>	9. AGE (In years lost birthday) <i>90</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>GEORGIA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Joseph Milligan</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-48-4223</i>		17. INFORMANT ADDRESS <i>Nola Chatman 3202 Sequoia Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>4123.71-250.4</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Broncho pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>422.1 II</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiosclerosis -</i>			
		(C) <i>generalized Arteriosclerosis</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Diarrhea and dehydration -</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>8-12-1968</i> to <i>8-23-1968</i> , that (I) (we) last saw the deceased alive on <i>8-23-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Bernito Martinez</i>		23B. DATE SIGNED <i>8-23-68</i>		23C. PHYSICIAN'S NAME (Type) <i>Bernito MARTINEZ</i>	
23D. ADDRESS <i>Bon Secours Hospital 2025 W. Fayette St.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/25/68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Local</i>		24D. LOCATION (City, town, or county) (State) <i>St. Petersburg, Fla.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 5 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Joseph L. Rues</i>		25D. ADDRESS <i>2222 W. North Ave</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

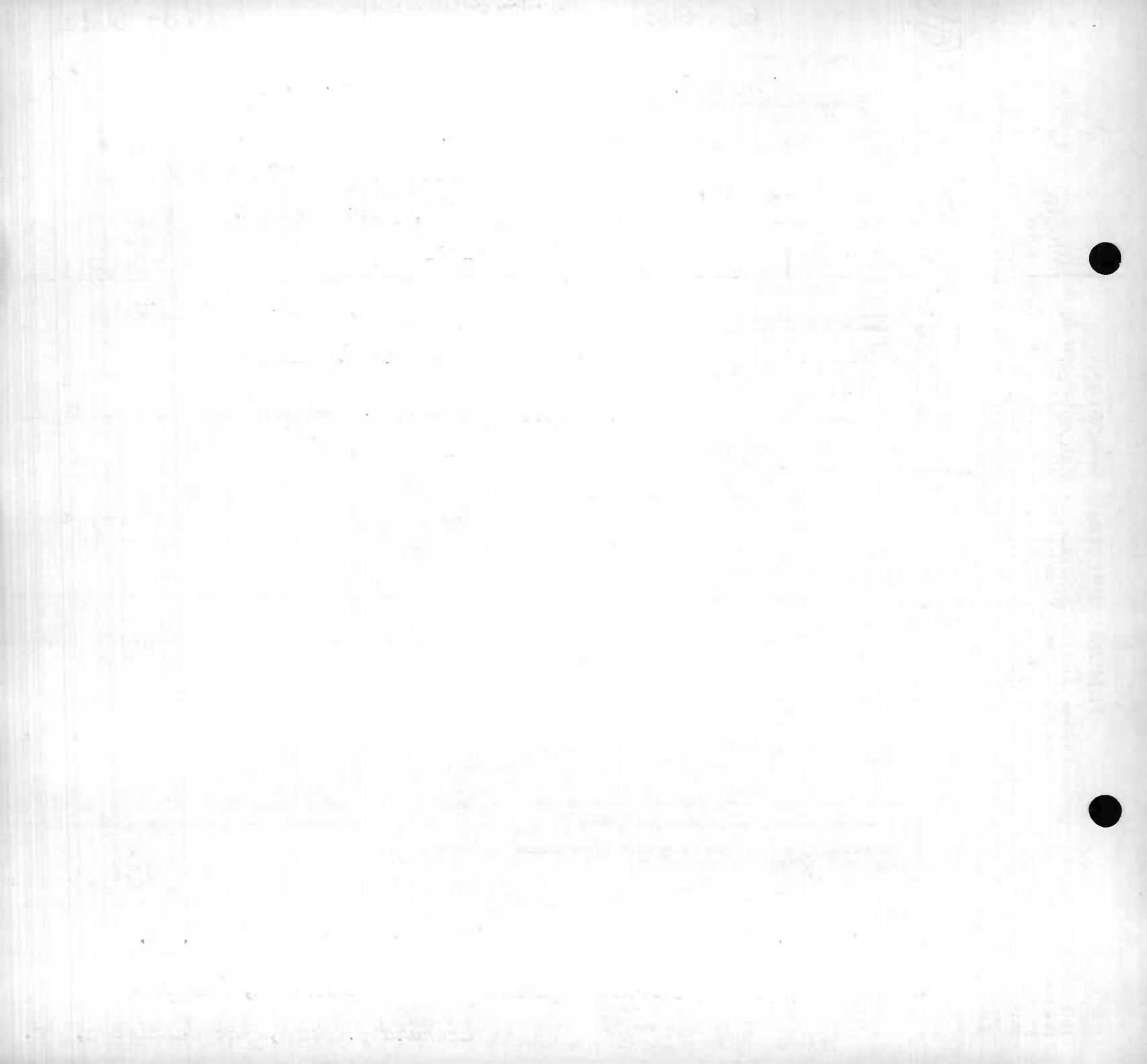
68- 9024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9024

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alfreda A. Adamson		Sept. 3, 1968 8:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
3019 Glenmore Ave. 00				Md. C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3019 Glenmore Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
female	white		2-18-1882	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Copenhagen, Denmark	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Carl Olsson			Bernarr A. Adamson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		096100475A		Bernarr A. Adamson same	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
arteriosclerotic heart disease					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
Rheumatoid arthritis					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
10 yrs					
10 yrs					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1 19 63 to Sept 3 19 68, that (I) (we) last saw the deceased alive on Sept 3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Edward J. Alessi				9/4/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Edward J. Alessi				6217 Harford Road Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	9/5/68	Ferndale Cemetery		Johnstown, New York	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
		Robert E. Johnson		Leonard J. Ruck, Inc Baltimore, Md.	

SEP 5 1968

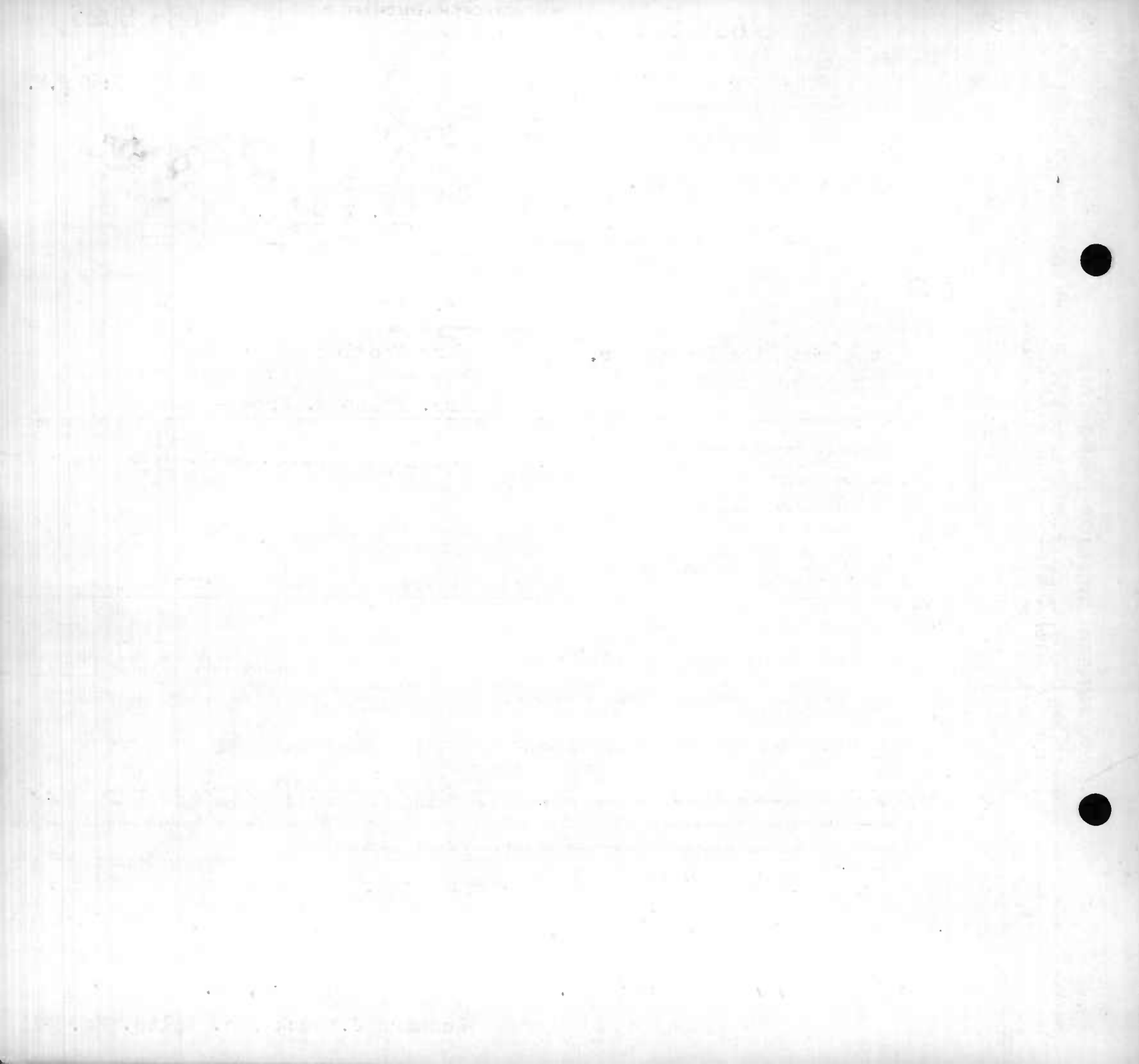


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 9025

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ETHELRED RICE BROWN, JR.		2. DATE AND HOUR OF DEATH September 3 1968 9:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore 12-06 INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 202 W. 29th St.	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1904	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Virginia	
13. FATHER'S NAME Ethelred Rice Brown Sr.			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213032526		17. INFORMANT Mrs. Helen C. Brown- Same	
18. 412.3 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-4-68 Oct. 67					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 9		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 10 19 67 to August 13 19 68 , that (I) (we) last saw the deceased alive on August 13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE C. E. Orange M.D. DEGREE				23B. DATE SIGNED 9-4-68	
23C. PHYSICIAN'S NAME (Type) CARLOS E. AARABSA DEGREE				23D. ADDRESS 5428 Sinclair Lane Balt. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/68		24C. NAME OF CEMETERY or CREMATORY Maury Com.	
24D. LOCATION (City, town, or county) (State) Richmond, Va.		25A. DATE RECEIVED BY HEALTH DEPT. SEP 5 1968			
25B. NAME OF REGISTRAR Robert E. Scharf		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. #14			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

68- 9026

BIRTH NO. <u>Laura V. Bennet</u>		2. DATE AND HOUR OF DEATH <u>9/13/68</u> <u>9:05 a.m.</u>	
1. NAME OF DECEASED (Type or Print) <u>LAURA V. BENNET</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3512 Ellerslie Ave.</u>	
5. SEX <u>F</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/84</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>83</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William W. Tolson</u>		14. MOTHER'S MAIDEN NAME <u>Laura Tolson Rollins</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-6633</u>	
17. INFORMANT <u>Agnes Ellerslie Doughter</u>		ADDRESS <u>same</u>	
18. <u>412.34-230.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mell.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:			
(B) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____			
19A. DATE OF OPERATION <u>1/8/21/68</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Jaundice @ post</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> <u>19 68</u> to <u>Sept. 3</u> <u>19 68</u> , that (I) (we) last saw the deceased alive on <u>Sept 3</u> <u>19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>J. J. Martinez M.D.</u> DEGREE <u>M.D.</u>			23B. DATE SIGNED <u>9/13/68</u>
23C. PHYSICIAN'S NAME (Type) <u>J. J. Martinez M.D.</u>			23D. ADDRESS <u>Maryland General Hospital.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/16/68</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> ADDRESS <u>Balto. Md.</u>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9027 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9027

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES HOWARD MELVILLE		2. DATE AND HOUR OF DEATH 9/3/68 1:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 9-23			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GEN. HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3617 OLD YORK RD.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN - RETIRED		10B. KIND OF BUSINESS OR INDUSTRY B & O RR		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES H. MELVILLE		14. MOTHER'S MAIDEN NAME ANNA SMITH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 2/3-05-2746		17. INFORMANT MRS. MILDRED B. MELVILLE	
		ADDRESS (SAME)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 + 415.7.9		CAUSE OF DEATH CARDIORESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) MYOCARDIAL INFARCTION			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		ADENOCARCINOMA - METASTATIC TO PERITONEUM, PROBABLY FROM PANCREAS			
19A. DATE OF OPERATION 18/9/68	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAP FOR SUSPECTED INTRA-ABDOMINAL CA	20A. AUTOPSY (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/17 19 68 to 9/3 19 68 , that (I) (we) last saw the deceased alive on 9/3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. M. De los Santos Jr., M.D.				23B. DATE SIGNED 9/8/68	
23C. PHYSICIAN'S NAME (Type) E. M. DE LOS SANTOS JR. M.D.				23D. ADDRESS M & A	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/6/1968	24C. NAME OF CEMETERY OR CREMATORY Parkwood	24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968	25B. NAME OF REGISTRAR R. E. E. Jenkins	25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

THE WIND
2011-12-20 10:00

2 22 10 10

1000

1000-1000

1000-1000

1000-1000

1000-1000

1000

1000-1000

1000-1000

1000

1000

1000-1000

1000-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9028

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EVENA LEAVERTON		2. DATE AND HOUR OF DEATH SEPT 3 1968 1 50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN PERRY HALL 21128	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 9909 FORGE PARK ROAD			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1894		9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALBERT EGE BERG			
14. MOTHER'S MAIDEN NAME ALICE M. ARNOLD		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 216-09-5493B		17. INFORMANT PAUL S. LEAVERTON (SAME)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		(B) DUE TO, OR AS A CONSEQUENCE OF: ADENOCARCINOMA OF RECTUM			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		7-8 MONTHS			
19A. DATE OF OPERATION 8/14/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER OF RECTUM		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A	
21D. TIME OF INJURY (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (H) (this hospital) attended the deceased from 8/3 19 68 to 9/3 19 68 , that (H) (we) last saw the deceased alive on 9/3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Stuart H. Spielman M.D.		23B. DATE SIGNED Sept 3 1968		23C. PHYSICIAN'S NAME (Type) STUART H. SPIELMAN	
23D. ADDRESS SINAI HOSP OF BALTO		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/6/1968		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Grds.		24D. LOCATION (City, town, or county) (State) Timonium, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

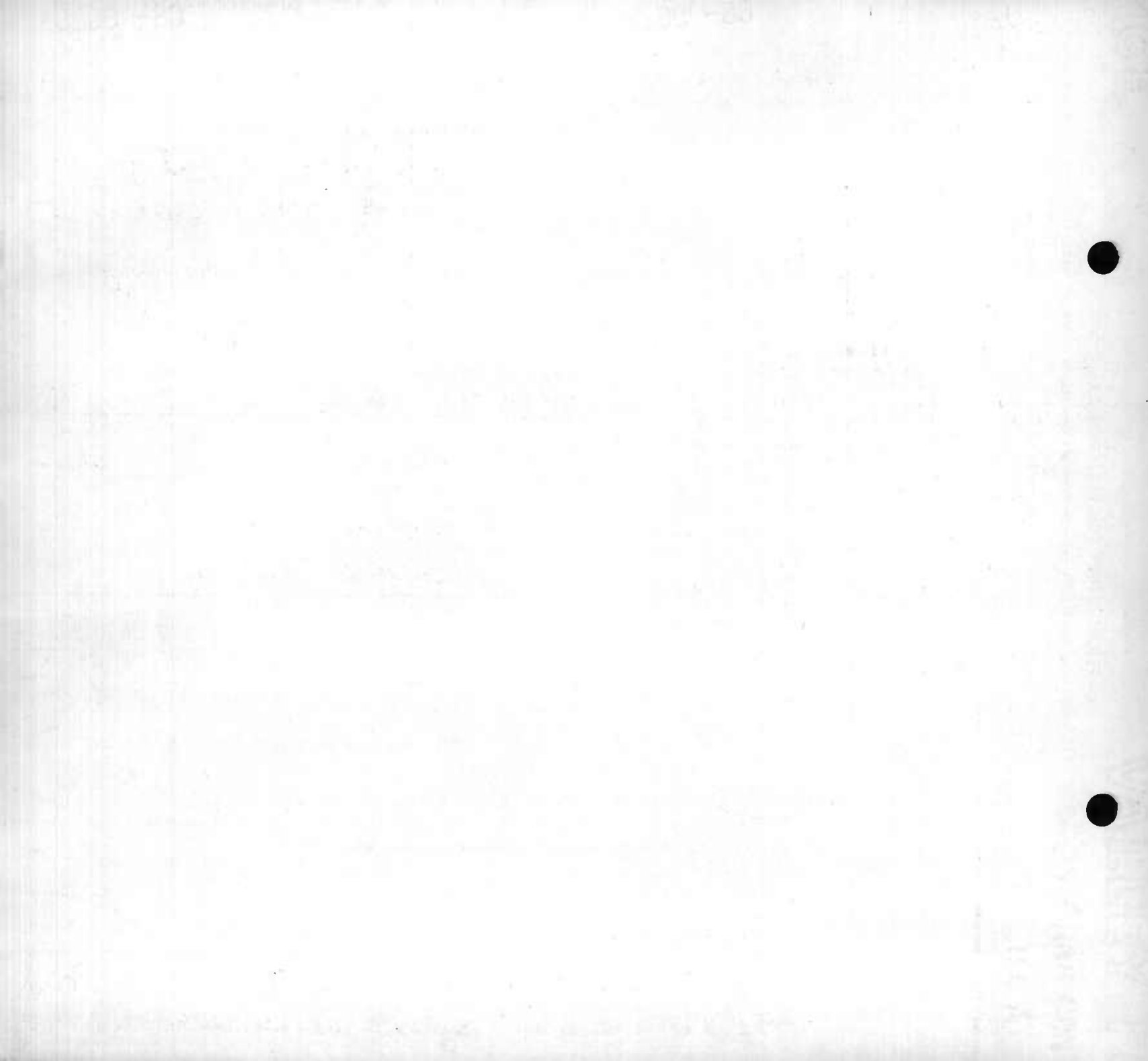
68- 9029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9029

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RANDALL BERNARD HARRY		2. DATE AND HOUR OF DEATH 3⁰⁰am 8-31-68 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY B. Charles St.			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital, Balto MD. 42		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto MD D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) taxi driver		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 3-8-15 9. AGE (In years lost birthday) 53	
11. BIRTHPLACE (State or foreign country) Balto, MD		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry Randall	
14. MOTHER'S MAIDEN NAME Sonia Owensky		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 217-09-9071	
17. INFORMANT Mrs Ida Pearlman		ADDRESS 8212 Marcie Dr.		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 420.1 II		(B) hypotension DUE TO, OR AS A CONSEQUENCE OF:		12h.	
(C) myocardial infarction				poss 12h.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 8-31-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. DATE OF OPERATION 8-31-68		19D. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8-12 19 68 to 8-31 19 68 , that (1) (we) last saw the deceased alive on 8-31 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gian Caggiano MD.		23B. DATE SIGNED 8-31-68		23C. PHYSICIAN'S NAME (Type) GIAN CAGGIANO	
23D. ADDRESS Sinai Hospital Balto MD.		23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/1/1968		24C. NAME OF CEMETERY or CREMATORY Mosco Montpelier	
24D. LOCATION Balto		24E. LOCATION Balto		24F. LOCATION Balto	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC 9610 Reisterstown Rd	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9030

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anne W. Dunkel

2. DATE AND HOUR OF DEATH

8/31/1968

122 4 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md. Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

218 E. Preston Street

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9 -6-1890

9. AGE (In years
last birthday)

77

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

clerk retired

10B. KIND OF BUSINESS OR INDUSTRY

state tax division
State of Md.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Irvine T. Dunkel

14. MOTHER'S MAIDEN NAME

Sarah Pugh

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218 36 1082

17. INFORMANT

ADDRESS

Louise D. Dunkel 218 E. Preston St.

18. 410.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHmyocardial infarction immediate
ASCD
Syn.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At
Work ☐Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/15 1968 to 8/31 1968.
that (I) (we) lost saw the deceased alive on 8/15 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

Allan Topper MD

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

8/31/68

23C. PHYSICIAN'S
NAME (Type)

Allan Topper

DEGREE

23D. ADDRESS

7501 York Rd.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/2/1968

24C. NAME of CEMETERY or CREMATORY

St. Johns Cemetery

24D. LOCATION

Ellicott City

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 5 1968

25B. NAME OF REGISTRAR

Robert E. Tashuma

25C. FUNERAL DIRECTOR

Mitchell Wiedefeld Home 6500 York Rd.

ADDRESS

1/1

2/1/12

referred information

ACMD

2/1/12

00

00

8/12

00

and

from other

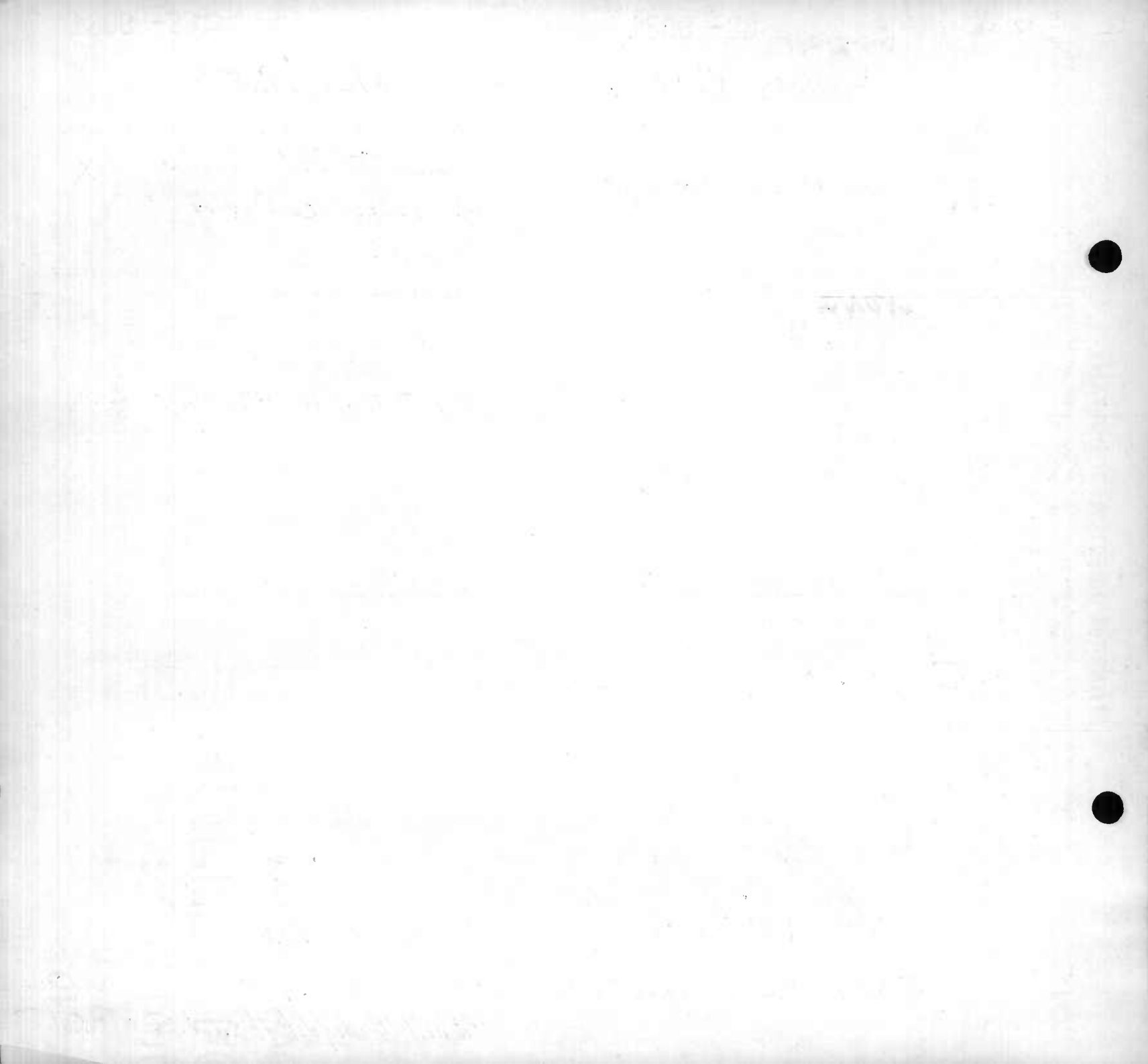
0

0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 9031 CERTIFICATE OF DEATH					REG. NO. 68- 9031				
BIRTH NO. 65-21291					2. DATE AND HOUR OF DEATH 8/30/1968 M.				
1. NAME OF DECEASED (Type or Print) Himes Patricia Lynn					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 38 University Hospital.					C. CITY OR TOWN Joppa Towne D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital.					E. STREET AND NUMBER 418 HARKSPURGE DRIVE				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/65	9. AGE (In years last birthday) 3	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY?		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore Md			
13. FATHER'S NAME John Himes			14. MOTHER'S MAIDEN NAME Margaret Smith						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT John H. Himes - 418 Harkspurge Dr.				ADDRESS
18. 7463 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Congenital heart diseases DUE TO, OR AS A CONSEQUENCE OF:						
(C) _____									
19A. DATE OF OPERATION 8/29/68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED V.A. COMMUNISM			20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. M. Juanter MD. DEGREE					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8/30/68	
23C. PHYSICIAN'S NAME (Type) J. M. Juanter					23D. ADDRESS University Hosp.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/68		24C. NAME OF CEMETERY or CREMATORY Eastlawn Cemt			24D. LOCATION (City, town, or county) (State) Howard Co. Md		
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968			25B. NAME OF REGISTRAR Paul E. Farley			25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			ADDRESS 6500 York Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9032	
1. NAME OF DECEASED (Type or Print) RAYMOND THOMAS CROWLEY			2. DATE AND HOUR OF DEATH SEPTEMBER 3, 1968 1000 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 421 N. BRADFORD ST. 21224					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-02	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10B. KIND OF BUSINESS OR INDUSTRY BALTO CITY HOSP.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Crowley			
14. MOTHER'S MAIDEN NAME ANNA KROUSE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214-015261		17. INFORMANT BCH: 4940 EASTERN AVE. BALTO., MD. 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1621 I CARCINOMA OF LUNG ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 1631 II Recurrent Pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
19A. DATE OF OPERATION 2 8/1/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cc of LUNG		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUG 26 1968 to SEPT 3 1968 , that (I) (we) last saw the deceased alive on SEPT 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald J. Saltzman M.D.				23B. DATE SIGNED Sept. 3, 1968	
23C. PHYSICIAN'S NAME (Type) DONALD SALTZMAN M.D.				23D. ADDRESS BCH: 4940 EASTERN AVE. BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Sept 7, 1968		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem	
24D. LOCATION (City, town, or county) (State) BALTO MD.		25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR 2534 Jefferson St. Healy Miller			

10-23

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9033 4	
<div style="display: flex; justify-content: space-between;"> MMCL 4521 68- 9033 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) VALENZIA, BABY BOY			2. DATE AND HOUR OF DEATH SEPTEMBER 1, 1968 10:10A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 19-04 C. CITY OR TOWN BALTIMORE, 21223 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 42 SO. FULTON AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/01/68	9. AGE (In years last birthday) 2	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN			11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? 2
13. FATHER'S NAME FRANK VALENZIA			14. MOTHER'S MAIDEN NAME ELSIE (JOY) VALENZIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT WILKENS & CATON AVES. ST. AGNES RECORDS-BALTIMORE, MD. 21229		
18. 772X I CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Immaturity</i> </div> <div style="width: 50%;"> (B) DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="width: 50%;"> (C) DUE TO, OR AS A CONSEQUENCE OF: </div> </div>					
19. 776X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 1, 1968 to SEPTEMBER 1, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPTEMBER 1, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Maria D. Giron M.D.</i>				23B. DATE SIGNED SEPT. 1, 1968	
23C. PHYSICIAN'S NAME (Type) MARIA D. GIRON, M.D.				23D. ADDRESS WILKENS & CATON AVES ST. AGNES HOSPITAL-BALTIMORE, MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 09/04/68		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968			
25B. NAME OF REGISTRAR <i>Robert E. Walters</i>		25C. FUNERAL DIRECTOR WALTERS FUNERAL HOME PRATT & STRICKER STS.			

VALERIA, BABY OF

SEPTEMBER 1, 1932

REPORT

X

SEPTEMBER 1, 1932

IN 32, EIGHTH AVENUE

REPORT

WHITE

SEPTEMBER 1, 1932

REPORT

SEPTEMBER 1, 1932

VALERIA

ST. LOUIS RECORDS - 1932

MD

SEPTEMBER 1, 1932

SEPTEMBER 1, 1932

KXX

X

SEPTEMBER 1, 1932

ST. LOUIS RECORDS - 1932

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9034 BALTIMORE CITY HEALTH DEPARTMENT
68- 9034 CERTIFICATE OF DEATH

REG. NO.

68- 9034

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WISE, ROSE L.		2. DATE AND HOUR OF DEATH SEPT. 3, 1968 8:47 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES ST.		A. STATE MD.	
BALTIMORE, MD.				B. COUNTY BALTIMORE CITY	
		C. CITY OR TOWN BALTIMORE CITY		D. INSIDE CITY LIMITS? YES	
		E. STREET AND NUMBER 5300 HADDON AVE. BALTO. MD. 21207			
5. SEX Female	6. RACE W hite	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/91	9. AGE (In years lost birthday) 77 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria	
13. FATHER'S NAME JOSEPH COHEN		14. MOTHER'S MAIDEN NAME ANNA HESSEL		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-14-5294		17. Informant Margaret J. Wise - Same	
				ADDRESS N. Charles St.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT. 3, 1968 to SEPT. 3, 1968 , that (I) last last saw the deceased alive on SEPT. 3, 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Deogracias V. Faustino, M.D.				23B. DATE SIGNED SEPT. 3, 1968	
23C. PHYSICIAN'S NAME (Type) DEOGRACIAS V. FAUSTINO, M.D.		23D. ADDRESS NORTH CHARLES GEN. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-5-68	24C. NAME OF CEMETERY or CREMATORY Arlington Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Av	

1
D-210

68- 9035 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9035

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JOSEPH ERIC ROBERT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 31 68 2:15 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 31, 1968 2:15 p M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
7. RACE Colored		C. CITY OR TOWN Balto.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 17-02	
9. DATE OF BIRTH 1-7-1949		E. STREET AND NUMBER 1117 Argyle Ave.	
10. AGE (In years last birthday) 19		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William R. Joseph	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Mary Briscoe		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Mary B. Jospheh - 1117 Argyle Ave.	
19. 304.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Intravenous Narcotism		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 323X II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 1, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-5-68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Charles R. Law	
25C. FUNERAL DIRECTOR 802 Madison Avenue		25D. ADDRESS	

Page 1

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

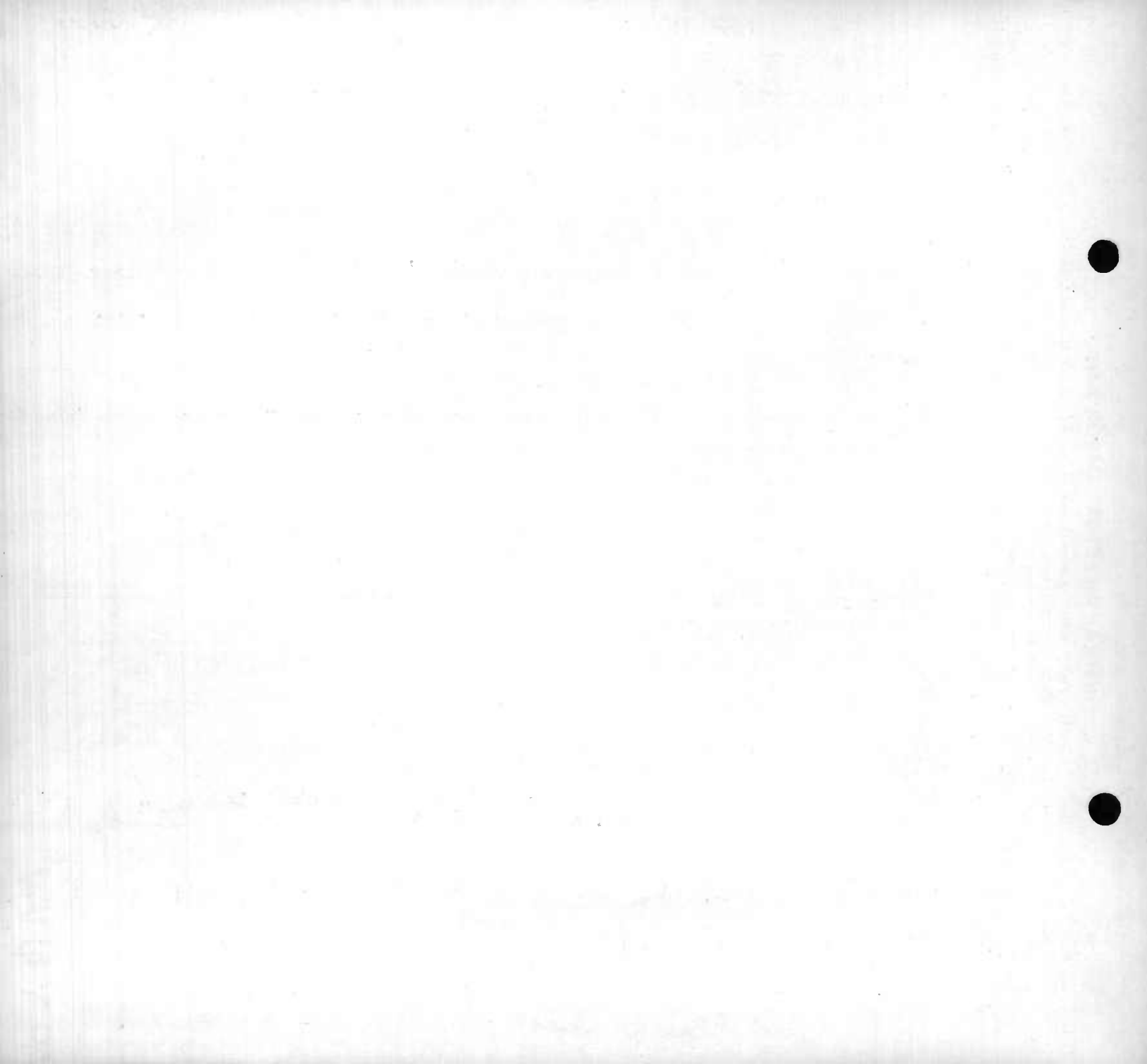
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9036 CERTIFICATE OF DEATH

REG. NO. 68- 9036

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM ATWELL JONES		SEPT. 1, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
00 4609 W. FOREST PARK AVE.		MARYLAND		C. CITY OR TOWN BALTIMORE	
		E. STREET AND NUMBER 4609 W. FOREST PARK AVE.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	COLORED	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	OCT. 27, 1897	70	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PHYSICIAN				SO. HAMPTON CO., VIRGINIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
THOMAS JONES		ANNIE DAVIS		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				ADDRESS	
				MRS. ERDIE E. JONES # 4609 W. FOREST PARK AVE.	
18. 153.8 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		generalized carcinoma bmo	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:		carcinoma of the colon 18 mo.	
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
153.8 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 27 1968 to Sept 1 1968, that (I) (we) last saw the deceased alive on Aug 27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
William H. Watts MD		9-4-68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
William H. Watts MD		515 N. Antietam Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		9-5-68		ARBUTUS MEMORIAL PARK	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 5 1968		Philip E. Taylor		CHARLES R. LAW - 802 MADISON AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 9037	
BIRTH NO.		68- 9037		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		VERA WEBB		September 1, 1968	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITAL		A. STATE MARYLAND		B. COUNTY Balt C 53-00	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		109 Oak Avenue	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 7-22, 1888	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Portsmouth, Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unk.			14. MOTHER'S MAIDEN NAME Sarah Ethridge		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Rev. Beulah Dodson 109 Oak Avenue	
18. 427.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
434.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 68 to 19 68 , that (I) (we) last saw the deceased alive on August 30, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. H. Conway				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS 914 D Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-4-68		24C. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.	

Copyright 1914

Copyright 1914

Copyright 1914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9038

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND (Alexander) ALEXANDRIA		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year September 2, 1968		Hour 2:00 P.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 2, 1968		Hour 2:00 P.
6. SEX male		7. RACE negro		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH July 31, 1967		10. AGE (In years last birthday) 13		E. STREET AND NUMBER 514 Lynhurst St.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Ronald J. Alexander
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary Ann Alexander
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. -8-		18. INFORMANT Mr. Henry J. Alexander
19. 746.91		CAUSE OF DEATH Congenital Heart Disease		ADDRESS 514 Lynhurst St.
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION 7-5-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/3/68
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-5-68		24C. NAME OF CEMETERY or CREMATORY Western Star Cem.
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Philip E. Farber		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.
		ADDRESS 1701 Laurens St.		

— J. B. [unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9039 CERTIFICATE OF DEATH

REG. NO. 68- 9039

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FLANAGAN EBENEZER		2. DATE AND HOUR OF DEATH 9-1-68 3:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-14-1890		9. AGE (In years last birthday) 78		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10B. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) British West I. Jamaica	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Dorothy Johnson ADDRESS 711 N. Carrollton Ave.	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Pneumonia and A.s.c.v.D ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia A.s.c.v.D		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia and A.s.c.v.D (B) Pneumonia A.s.c.v.D DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-28-1968 to 9-1-1968 , that (I) (we) last saw the deceased alive on 9-1-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Baig		DEGREE		23B. DATE SIGNED 9-1-68	
23C. PHYSICIAN'S NAME (Type) Baig		DEGREE		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) Baltimore		(State) md		24E. FUNERAL DIRECTOR Horton E. Dyett F.H.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS 1701 LAURENS ST	

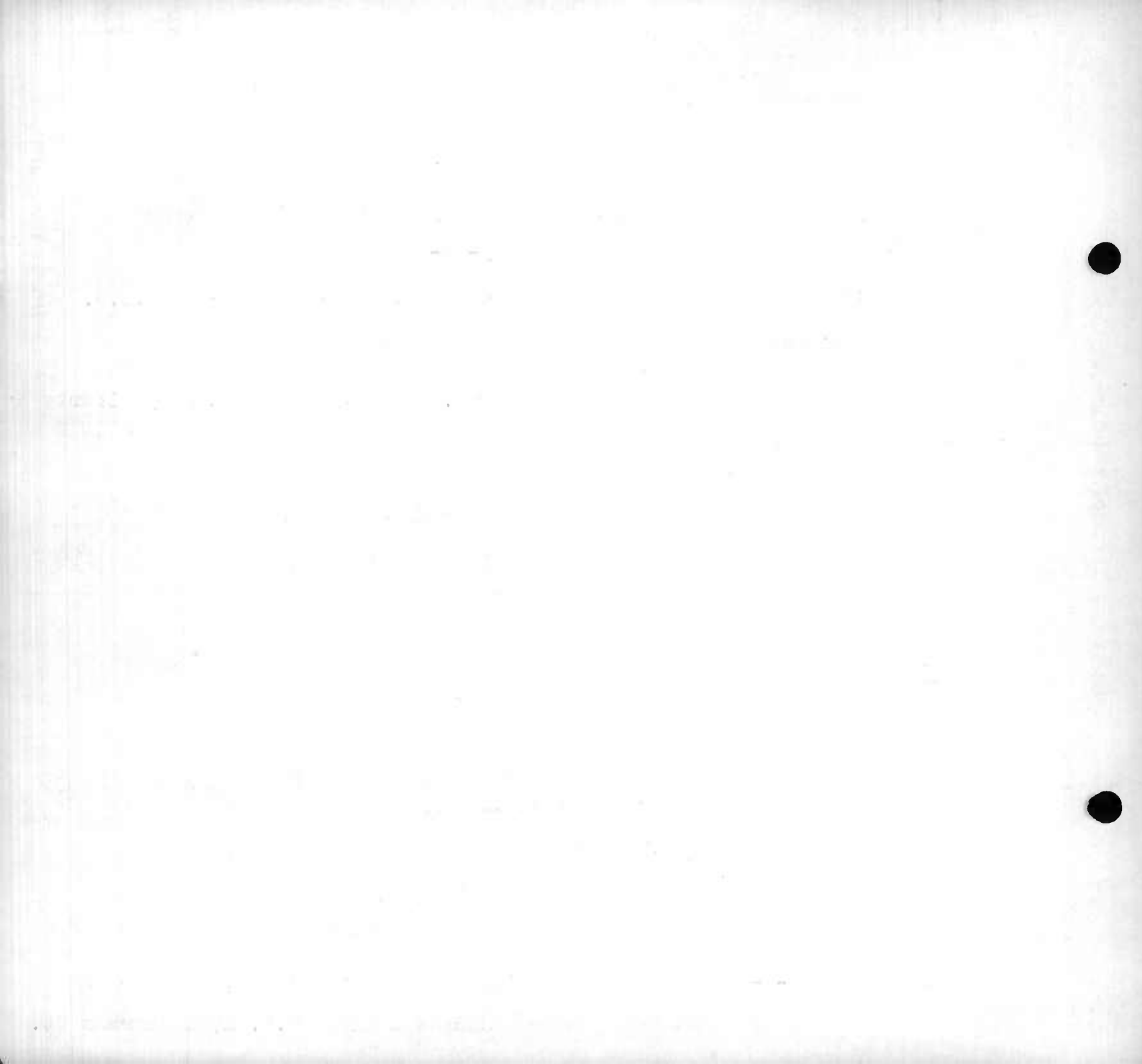
the following places: 20 in (1000)
all the following places: 20 in (1000)
all the following places: 20 in (1000)
all the following places: 20 in (1000)

Received of the Treasurer of the County of ...
the sum of ... Dollars ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

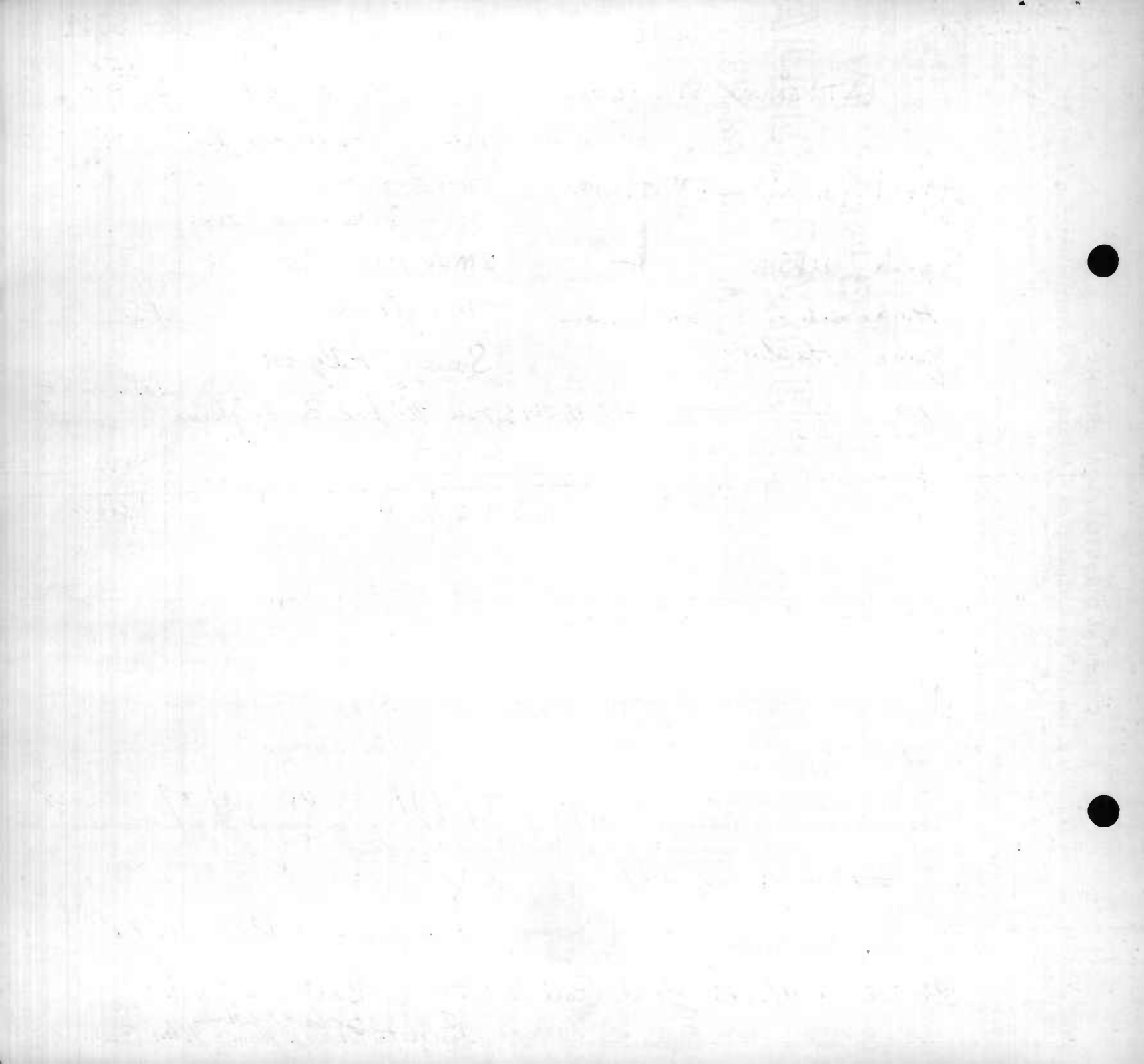
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 9040	
BIRTH NO.		68- 9040		CERTIFICATE OF DEATH	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		ROSANNA BROWN		2. DATE AND HOUR OF DEATH September 1, 1968	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
2603 Liberty Heights Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		2603 Liberty Heights Avenue	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 3-16-1887	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Columbia, South Carolina	
13. FATHER'S NAME Warren Alfred		14. MOTHER'S MAIDEN NAME Rosie Alfred		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Estelle Robertson 2603 Liberty Hg	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Respiratory failure (B) DUE TO Hypertension & arteriosclerosis (C) DUE TO Coronary vascular renal disease		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 26 1968 to Sept 1 1968, that (I) (we) last saw the deceased alive on Aug 26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Shorofsky		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/3/68	
23C. PHYSICIAN'S NAME (Type) S B O R O R S K E Y		23D. ADDRESS 601 N. Howard St Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-5-68		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9041
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Catherine Mason</i>		2. DATE AND HOUR OF DEATH <i>9-3-68 2:25 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Hood Pines Funeral Home</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Anne Arundel</i>		C. CITY OR TOWN <i>Glen Burnie</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Hood Pines Funeral Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>7002 Delmar Ave.</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8 MAR. 1883</i>	9. AGE (In years lost birthday) <i>85</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John Harkin</i>		14. MOTHER'S MAIDEN NAME <i>Sara F. Flynn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>217-48-7893</i>		17. INFORMANT <i>Mrs. Mildred Buckingham</i>	
18. <i>412.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>C.V.A</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>A.S.H.C.V.D</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>443X II</i>					
19A. DATE OF OPERATION <i>9/3/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/1/71</i> to <i>9/3/68</i> that (I) (we) last saw the deceased alive on <i>9/3/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Adnan Sornomez</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Adnan Sornomez</i>		23D. ADDRESS <i>1011 Frederick Road 21228</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/4/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Landon Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Robert E. Taylor</i>		25D. ADDRESS <i>Singletts Funeral Home - Glen Burnie, md.</i>			

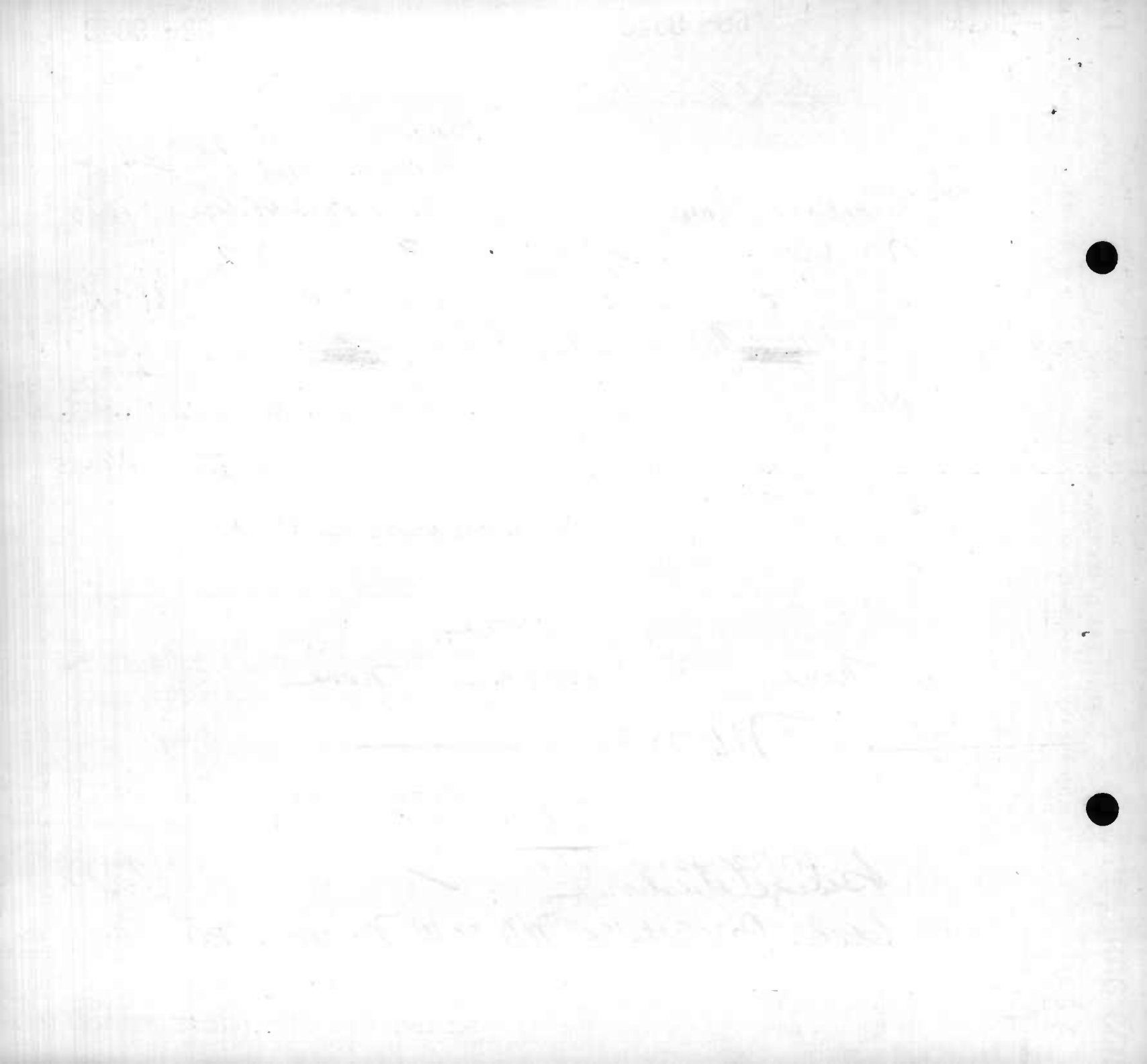


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

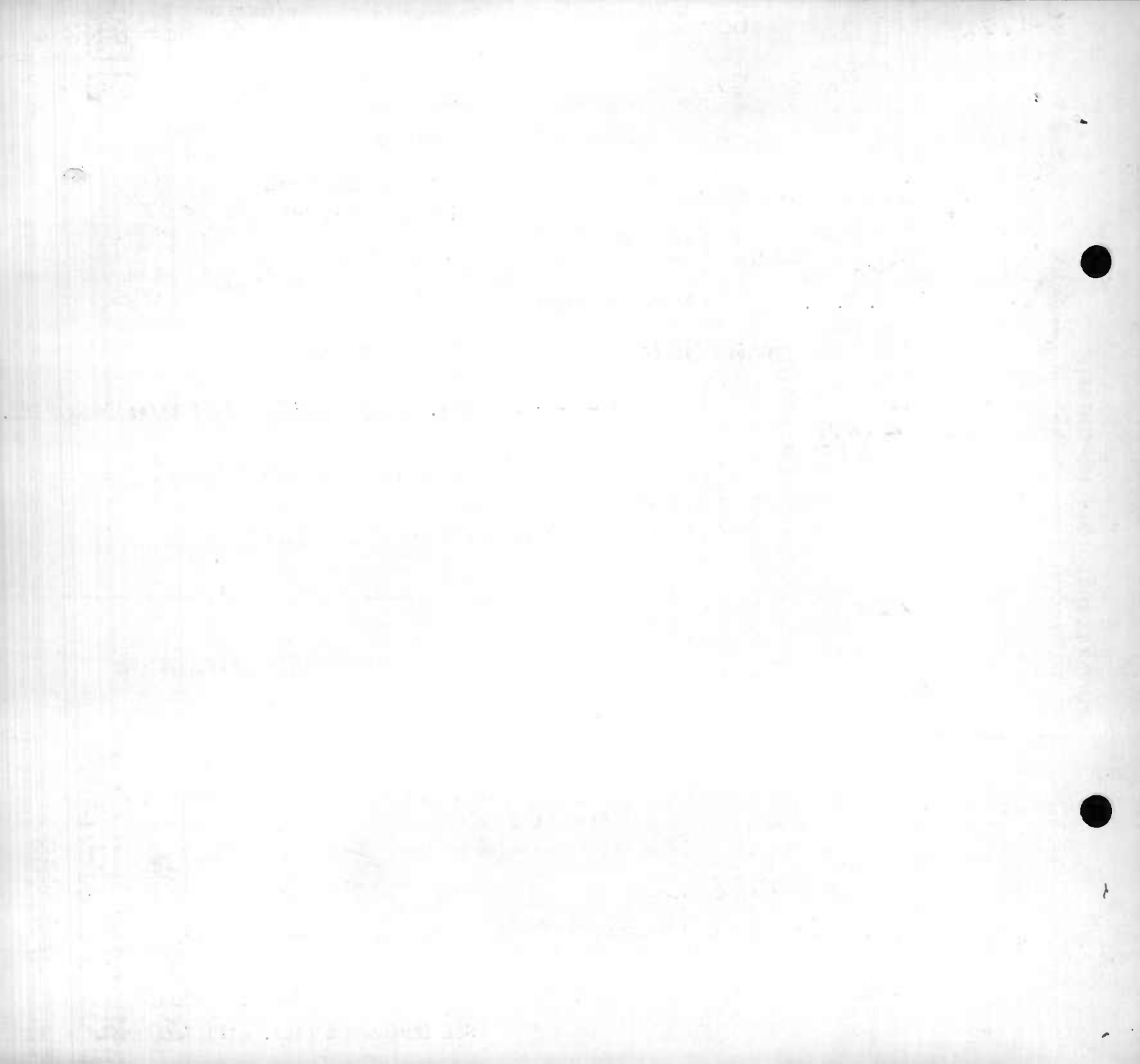
BALTIMORE CITY HEALTH DEPARTMENT
68- 9042 CERTIFICATE OF DEATH 8/30/68 REG. NO. 68- 9042

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RUBIN COHEN		2. DATE AND HOUR OF DEATH 8/30/68 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTO MD B. COUNTY		C. CITY OR TOWN BALTO. MD D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION JEWISH CONVALESCENT HOME		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 3604 Park Heights Ave 21215	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/1886	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hyman Herman Cohen		14. MOTHER'S MAIDEN NAME Ressa Golda?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT MR. MATTHEW COHEN, 3001 ROMARIC CT., APT. D	
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE M.I. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. HYPERTENSIVE C.V.D.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE M.I. (B) HYPERTENSIVE C.V.D. DUE TO, OR AS A CONSEQUENCE OF: (C) NONE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH NONE	
19. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) NONE	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/30 1968 to Death 19 , that (I) (we) last saw the deceased alive on 8/30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George A. Besenhouse		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/30/68	
23C. PHYSICIAN'S NAME (Type) GEORGE ABESHOUSE MD		23D. ADDRESS 60 W. Monument St Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-1-68	24C. NAME of CEMETERY or CREMATORY HEBREW YOUNG MEN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

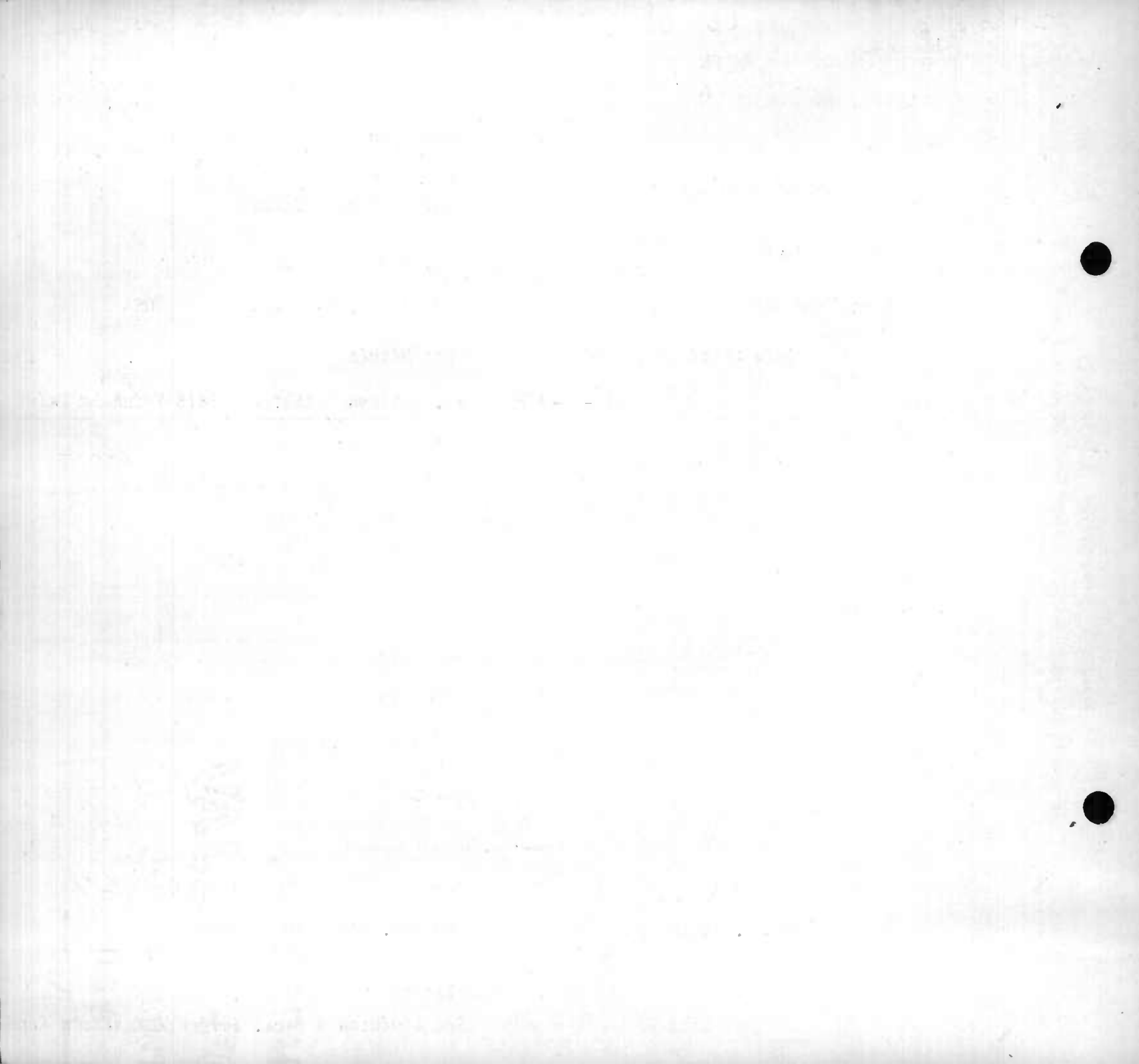
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9043
BIRTH NO.		68-9043		
1. NAME OF DECEASED (Type or Print) LOUIS GIRSHIN		2. DATE AND HOUR OF DEATH 9-1-68 6:06 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6651 DALTON DR. #07		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/09	9. AGE (In years last birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. P. A.		10B. KIND OF BUSINESS OR INDUSTRY Isaac Hamburger		11. BIRTHPLACE (State or foreign country) U.S. - (Baltimore)
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Morris Girshin		
14. MOTHER'S MAIDEN NAME Katie Fradin		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		
16. SOCIAL SECURITY NO. 215-07-5697		17. INFORMANT Mrs. Minnie Girshin		
18. 442X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Dissecting Aneurysm Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 452X II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9-1-68 19 to 9-1-68 19, that (I) (we) last saw the deceased alive on 9-1-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. Chloa		23B. DATE SIGNED 9-1-68		23C. PHYSICIAN'S NAME (Type) ISAAC R. CHLOA, M.D.
23D. ADDRESS Sinai Hospital		24. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 9/2/1968		24C. NAME OF CEMETERY or CREMATORY Beth Tfiloh		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-9044
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		AARON SIDNEY A. BERSHTEIN		9-1-68 11:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
42 Sinai Hospital			Maryland Baltimore 53-00		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			3418 Vataruba Drive		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 1, 1930	38	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Store Manager		Retail		Baltimore, Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Late Morris Bershtein			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			214-26-9617		Mrs. Marilyn Bershtein 3418 Vataruba Drive
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			Acute Coronary Thrombosis		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Recurrent Coronary Thrombosis		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1942 to 9-1-68, that (I) (we) last saw the deceased alive on 9-1-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Milton B. Kirsh				9-1-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Milton B. Kirsh				4000 W. Northern Parkway	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/2/1968		Mikro Kodesh Beth Israel	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 5 1968		Robert E. Jankins		Sol Levinson & Bros. 6010 Reisterstown Road	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9045
B-655		68-9045		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SAMUEL BARMAN		2. DATE AND HOUR OF DEATH SEPT. 1, 1968 1:25 P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME & HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND D.S.A. 6-23 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 136 N. COLLINGTON AVE. (31)		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-92	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER NEW CATHEDRAL		10B. KIND OF BUSINESS OR INDUSTRY RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MARK BARMAN		14. MOTHER'S MAIDEN NAME ANN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 27-18-0735A	17. INFORMANT MARTIN LILIAN (DAUGHTER) 136 N. COLLINGTON AVE. (31)	
18. 699.01		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Septicemia DUE TO, OR AS A CONSEQUENCE OF: (B) Bladder infection DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 609X II		Arteriosclerotic Heart Disease		
19A. DATE OF OPERATION Aug - 8, 1968	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED urinary retention	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 26 19 68 to Sept. 1 19 68 , that (I) (we) last saw the deceased alive on Sept. 1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Corazon Z. Vergara, M.D.		23B. DATE SIGNED September 1, 1968		23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.
23D. ADDRESS Church Home Hospital		24. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 9-3-68		24C. NAME OF CEMETERY or CREMATORY BNAI JACOB		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

DATE: 10-2-57

RECEIVED

DATE: 10-2-57

100 A. CORRECTION AVE. (21)

10-2-57

X

DATE: WHITE

RECEIVED

MARK BARMAN

ALIAN BUREAU (21)

RECEIVED

ALIAN BUREAU

ALIAN BUREAU

for

10-2-57

10-2-57

10-2-57

10-2-57

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9046
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>HELEN AMc KENNA</i>		2. DATE AND HOUR OF DEATH <i>9-1-68</i> <i>6.30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 MERCY HOSPITAL</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>703 Ector Ave.</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-27-04</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Patrick Moran</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Lane</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-36-0363</i>		17. INFORMANT <i>Medical Chart</i>	
18. <i>183.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Internal bleeding</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Generalized metastasis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Carcinoma of ovary</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
19. DATE OF OPERATION <i>18-31-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory</i>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-27</i> 19 <i>68</i> to <i>9-1</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9-1</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thinxorn Chennavasin</i>		23B. DATE SIGNED <i>9-1-68</i>		23C. PHYSICIAN'S NAME (Type) <i>THINAXORN CHENNAVASIN</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/5/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. NAME OF REGISTRAR <i>Robert E. Taylor</i>		24F. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 5 1968</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>3000 E. Baltimore St.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9047 CERTIFICATE OF DEATH

REG. NO. 68- 9047

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN F OKATCH		9-2-68 12:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
NORTH GEN. HOSPITAL				MARYLAND 2123753-00	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED - RED GRAIN				Pa. USA	
13. FATHER'S NAME (Print)				14. MOTHER'S MAIDEN NAME	
JOHN OKATCH				CHRISTINE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
N		21205-772		1 HOSP. CHART - NCGH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				36 hours	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
CONGESTIVE HEART FAILURE					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
HYPERTENSIVE CARDIOVASCULAR DISEASE (years)					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
DIABETES MELLITUS (years)					
(C) CVA					
MEDICAL CERTIFICATION					
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/30/68 to 9/2/68, that (I) (we) lost saw the deceased alive on 9/2/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
MARIANO A. TOLENTINO				9/2/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MARIANO A. TOLENTINO		NORTH CHARLES GEN HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/5/68		Gardens of Faith Cemetery, Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 5, 1968		Robert E. Farkas, Jr.		John A. Moran, Inc. 3000 E. Baltimore St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9048 CERTIFICATE OF DEATH

REG. NO. 68- 9048

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Eugene Francis McGrath</i>		2. DATE AND HOUR OF DEATH <i>Sept. 3, 1968</i> <i>11 A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMIT? <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>4475 Harcourt Rd.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/22/'05</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Savings Bank of Balto.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Michael J. McGrath</i>		
14. MOTHER'S MAIDEN NAME <i>Mary Catherine Nolan</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>213-18-1943</i>			17. INFORMANT <i>Miss Marie McGrath 4475 Harcourt Rd</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury at complication which caused death.) <i>420.1 II</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis Sudden + Immediate</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio Renal/Vascular Disease About 1 1/2 yrs.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Theodore H. Morrison, M.D.</i>				23B. DATE SIGNED <i>9/5/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Theodore H. Morrison, M.D.</i>				23D. ADDRESS <i>11 E. Chase St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/7/'68</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9049

BIRTH NO.

1. NAME OF DECEASED (Type or Print) IDA J. BATEMAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour September 3, 1968 7:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3/ Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour September 3, 1968 7:45 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-65		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Jan. 29, 1905		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) Craven County, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Assembly		14B. KIND OF BUSINESS OR INDUSTRY Glen L. Martin Co.	
15. MOTHER'S MAIDEN NAME Betty Sutton		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 232-30-3391		18. INFORMANT Paul Funeral Home Washington, N. C.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty Alteration of Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 5/7/68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/3/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-6-68	
24C. NAME of CEMETERY or CREMATORY Pamlico Memorial Gardens		24D. LOCATION (City, town, or county) (State) Washington, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Tankersley	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.		ADDRESS Towson, Md. 21204	

WALTER A. (10) (10)

R-260

68- 9050 BALTIMORE CITY HEALTH DEPARTMENT

68- 9050

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WYDELL RUCKER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 2, 1968 Hour 11:25 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Yard in front of 3018 DuPont Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour September 2, 1968 11:25 P.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH 9-19-35		10. AGE (In years lost birthday) 32	
11. BIRTHPLACE (State or foreign country) GA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS RUCKER		14. MOTHER'S MAIDEN NAME TASS	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		16. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II		18. SOCIAL SECURITY NO. 260-46-2640	
19. CAUSE OF DEATH E970X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Gunshot Wounds (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 2		21. CONDITION FOR WHICH OPERATION WAS PERFORMED Multiple Gunshot Wounds	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) yard (home)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3018 DuPont Avenue		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9/2/68 11:15 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? subj. shot by police	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) DATE SIGNED 9/3/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/68	
24C. NAME OF CEMETERY or CREMATORY Long Island Nat. Cemetery		24D. LOCATION (City, town, or county) (State) Farmingdale, N.Y.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR John E. Farley	
25C. FUNERAL DIRECTOR Wm. P. Chastain		25D. ADDRESS 1701 M.E. Calhoun St. Balto., Md.	

— ۱۳۰۲ —

WILLIAM COLEMAN WAS RELEASED ON APPROVAL BY DR. XXXX, SPITZ, MEDICAL EXAMINER
-455 68-9051
22-00-37
2024
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9051											
1. NAME OF DECEASED (Type or Print) WILLIAM E. COLEMAN				2. DATE AND HOUR OF DEATH 8-27-68 1:55 P M.															
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 1722 E. CHASE ST.				5. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
5. SEX MALE		6. RACE NEGROID		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-11-34		9. AGE (In years lost birth day) 34		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY Odd Jobs				11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CURTIS COLEMAN				14. MOTHER'S MAIDEN NAME HILDA CARTER COLEMAN															
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N				16. SOCIAL SECURITY NO. 912-26-446				17. INFORMANT Mrs Hilda Whitaker				ADDRESS 1826 E. Biddle St.							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease or injury or complication which caused death.) 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 581.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION GIVEN IN PART I				CAUSE OF DEATH IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASPIRATION PNEUMONIA SEIZURE, HEMIPARESIS CHRONIC ALCOHOLISM + CIRRHOSIS + FATTY LIVER FOLIC ACID DEFICIENCY WITH POLYCYTOPENIA 1 MON				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 hrs. 17 & about 24 hrs.											
19A. DATE OF OPERATION A				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?											
22. I certify that (II) (this hospital) attended the deceased from August 26 1968 to August 27 1968, that (I) (we) last saw the deceased alive on August 27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (II) (We) (did) (did not) view the body after death.												23A. SIGNATURE Douglas T. Fearon, M.D. DEGREE				23B. DATE SIGNED August 27, 1968			
23C. PHYSICIAN'S NAME (Type) DOUGLAS T. FEARON, M.D. DEGREE				23D. ADDRESS The Johns Hopkins Hospital, Balt. Md.															
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8-31-68		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery				24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.									
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968				25B. NAME OF REGISTRAR E. J. Taylor, MA				25C. FUNERAL DIRECTOR Randolph J. Tollick				ADDRESS 3431 E. Oliver St.							

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9052 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9052

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH PAPLAUSKAS		2. DATE AND HOUR OF DEATH 9-3-68 6:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 10-01			
FULL NAME OF HOSPITAL OR INSTITUTION 96 LITTLE SISTERS OF THE POOR 1200 VALLEY STREET BALTIMORE, MARYLAND 21202		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1200 VALLEY STREET					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-15-1883	9. AGE (In years lost birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY 68-8000		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME WILLIAM		14. MOTHER'S MAIDEN NAME MARION ?(UNKNOWN)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-8324A		17. INFORMANT Little Srs of The Poor	
18. 185X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Terminal Ca of prostate gland		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 to Sep. 3. 68 19 68 that (I) (we) lost saw the deceased alive on Sept 3. 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudas		23B. DATE SIGNED 9.5.68		23C. PHYSICIAN'S NAME (Type) Stanley Ankudas M.D.	
23D. ADDRESS 1101 MAIDEN CHOICE LANE Balt. Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	Sept 4/68	Holy Redeemer	Baltimore		
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Philip Herwig Sons	
25D. ADDRESS					

100

4



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MEDICAL CERTIFICATION

Released as Not a Medical Examiner Case by Dr. Gomez, per Mr. Gregory

68- 9053		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 9053	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		WILLIAMS, WILLIE		8-28-68 9:45 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
The Johns Hopkins Hospital		Baltimore		D. STREET ADDRESS (If rural, give location)	
2809 Kirk Avenue					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Negroid	Married	8/26/21	47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Truck Driver				N. C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
?		?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes World War #2				Annie Williams 2809 Kennedy	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I		(A) Pulmonary Embolus DUE TO			
1. This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.		(B) Thrombophlebitis of lower extremities DUE TO			
2. ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		Aortofemoral & Aortoiliac bypass surgery			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
8-28-68		Vascular insufficiency		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/4 1968 to 8/28 1968, that (I) (we) last saw the deceased alive on 8/28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Howard Snider		8/29/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Howard Snider, M.D.		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Aug 31/68		Rocky Mt. N. Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 5 1968		R. E. Jackson		Milton E. Eliskens 11297 Carolina	

Howard Hughes

2/20/50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9054

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9054

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alexander BRISCOE

2. DATE AND HOUR OF DEATH

9/3/68 7:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS

YES ☒

NO ☐

E. STREET AND NUMBER

1202 Mc Elderry Ct.

5. SEX

M

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3/15/1928

9. AGE (In years lost birthday)

70

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).

Retired Crane Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md. USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Alexander Briscoe

14. MOTHER'S MAIDEN NAME

Sarah Maryland

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Norothy Alfred 1519 E. Chas St

18.

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

SIMULTANEOUS

(B)

Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/1 1968 to 9/3 1968, that (I) (we) last saw the deceased alive on 9/3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John D. Stobo

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9/3

23C. PHYSICIAN'S NAME (Type)

JOHN D. STOBO

DEGREE

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 5 1968

Robert E. Johnson

Funeral Home 1129 N. Calhoun St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9055	
68- 9055				68- 9055	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Harriett Duncan</i>		2. DATE AND HOUR OF DEATH <i>August 30, 1968</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>5-05</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> <i>1844 N. Wolfe Street</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Female</i>			6. RACE <i>Chad</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>Jan. 4, 1888</i>	
13. FATHER'S NAME <i>Spotwood Garland</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Crowder</i>		9. AGE (In years last birthday) <i>80</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
17. INFORMANT <i>Thelma Ray</i>		ADDRESS <i>1004 N. Eden St</i>		12. CITIZEN OF WHAT COUNTRY?	
18. <i>4319 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i> (B) <i>Cerebral Arteriosclerosis</i> (C) _____		
19. <i>331X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1963</i> to <i>Aug 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug 28, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. M. Washington</i>				23B. DATE SIGNED <i>9/3/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>F. W. Washington, M.D.</i>				23D. ADDRESS <i>2309 Druid Hill Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>Sept 3/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>A. A. County Md</i>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Milton E. Eliskorn</i>	
25C. FUNERAL DIRECTOR <i>11297, C...</i>		25D. ADDRESS		25E. DATE	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9056 CERTIFICATE OF DEATH

REG. NO. 68- 9056

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JEANETTE JACOBS		2. DATE AND HOUR OF DEATH 9-3-68 10:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY		5. AGE (In years last birthday) 42	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 4-29-26	
13. FATHER'S NAME ADOLPHUS SHERRY		14. MOTHER'S MAIDEN NAME GERTRUDE BYRD		9. AGE (In years last birthday) 42	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Bald, Md	
17. INFORMANT Joseph Jacobs		ADDRESS 1653 N. MILTON AVE.		12. CITIZEN OF WHAT COUNTRY?	
18. 430.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intracerebral Hemorrhage		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 331X II		20A. AUTOPSY? (Yes or No) Yes	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 2 1968 to Sept 3 1968 , that (I) (we) lost saw the deceased alive on Sept 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David A. Bass MD		DEGREE		23B. DATE SIGNED 9/3/68	
23C. PHYSICIAN'S NAME (Type) DAVID A. BASS MD		DEGREE		23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/68		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem	
24D. LOCATION (City, town, or county) (State) Westport MD		25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Joseph T. Elisean		ADDRESS 1129 N. Calhoun			

Interlocking Hardware

W

W

W

2/22/74

2/22/74

2/22/74

David A. Jones MD

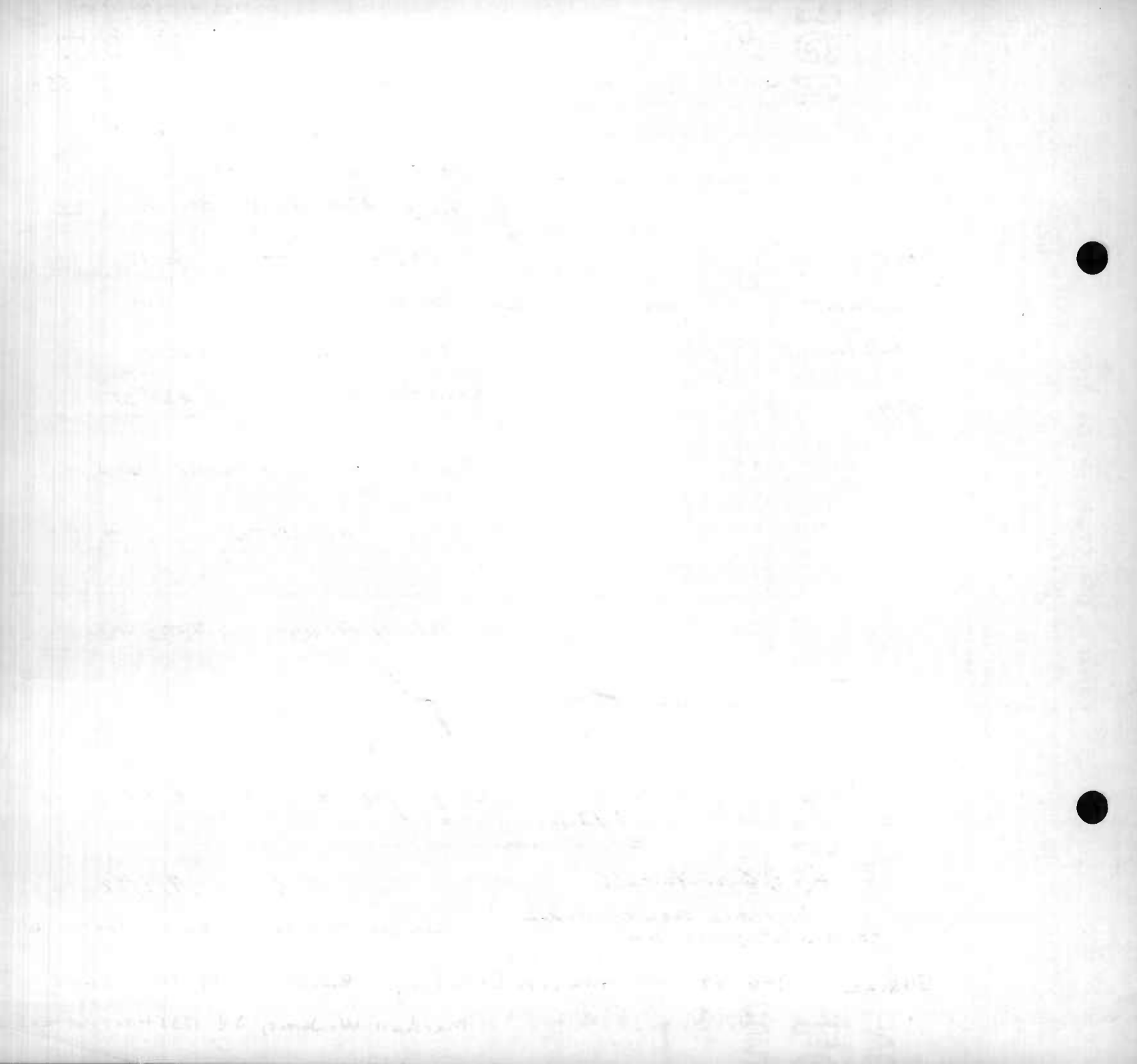
David A. Jones MD

John H. Jones MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>154-6021</u> ✓	
BIRTH NO. <u>154-6029-68-9057</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>HARRISON RODNEY</u>				2. DATE AND HOUR OF DEATH <u>9/3/68</u> <u>8:55</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL BALTIMORE</u> <u>44</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>BALTIMORE</u> CITY <u>MARYLAND</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/> E. STREET AND NUMBER <u>706 E 43rd STREET BALTIMORE MD.</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEG</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>02/16/68</u>	9. AGE (In years last birthday) <u>6</u> <u>17</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NOT APPLICABLE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>REGINALD EUGENE</u>			14. MOTHER'S MAIDEN NAME <u>GLORIA ANN FRAZER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>N.A.</u> <u>NA.</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT ADDRESS <u>REGINALD HARRISON 706 E. 43rd ST</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>773.0 II</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ACUTE LIVER FAILURE</u> DAYS DUE TO, OR AS A CONSEQUENCE OF: (B) <u>NEONATAL HEPATITIS</u> FROM BIRTH DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>773.0 II</u>			<u>BILATERAL PLEURAL EFFUSIONS AND ARTERIES</u> DAYS		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>-</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>02/16/68</u> to <u>9/3/1968</u> , that (2) (we) last saw the deceased alive on <u>9/3/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. J. Cantwell</u> DEGREE				23B. DATE SIGNED <u>9/3/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>RONALD JOHN CANTWELL</u> <u>MB. M.D. M.A.C.P. D.E.H.</u> DEGREE				23D. ADDRESS <u>UNION MEMORIAL HOSP. BALTIMORE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-6-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. CITY, Maryland</u>		24E. FUNERAL DIRECTOR ADDRESS <u>Marshall W. Jones, JR. 1735 Harford Ave.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Marshall W. Jones, JR. 1735 Harford Ave.</u>	



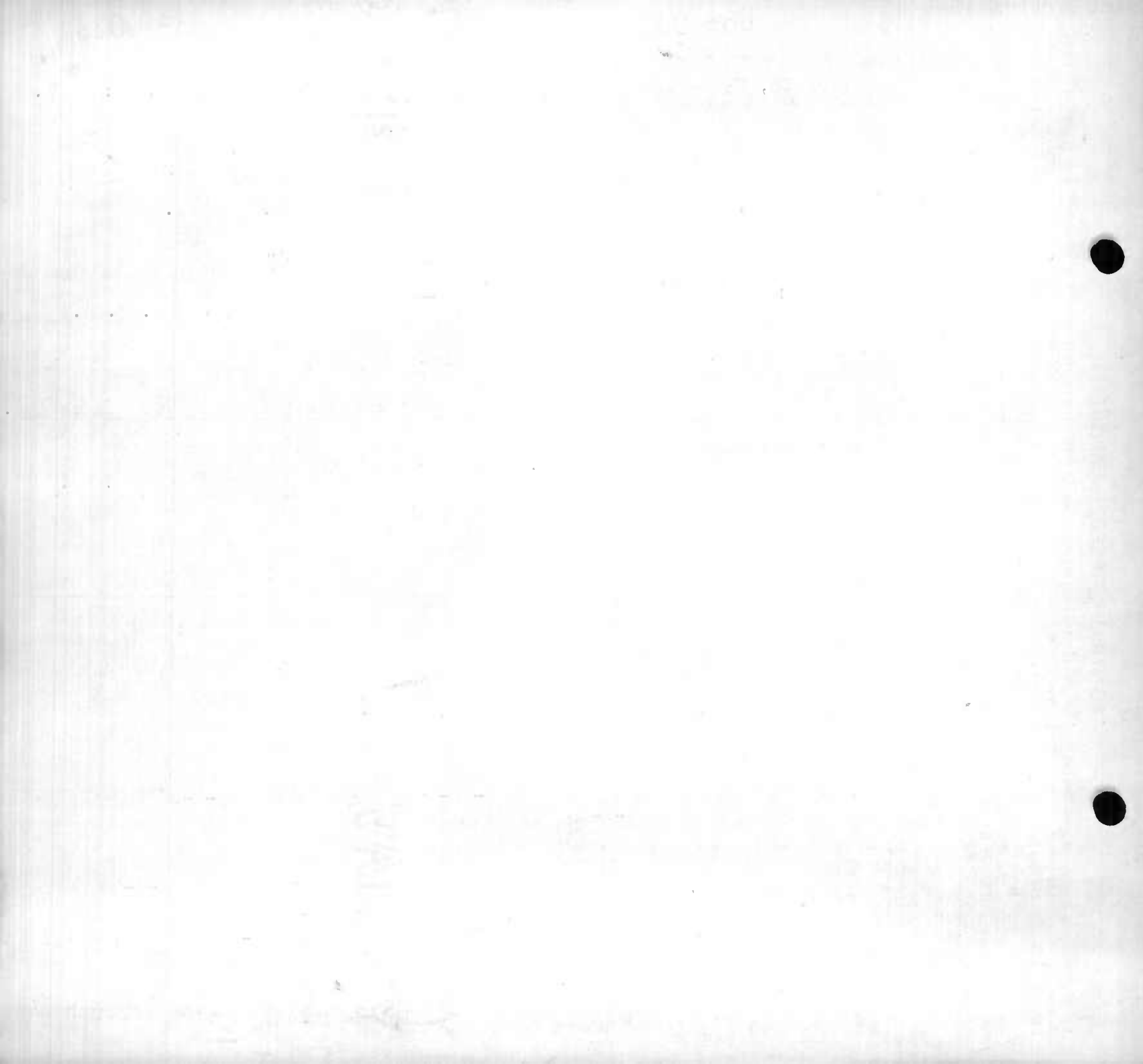
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9058 CERTIFICATE OF DEATH

REG. NO. 68- 9058

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Davis, Catherine		9-2-68 10:30 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 1514 Division Street Baltimore, Maryland				A. STATE Maryland	
				B. COUNTY	
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1613 Gwynn Falls Pkwy.	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-5-04	9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Johnson				14. MOTHER'S MAIDEN NAME Georgia Hall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-18-1239		17. INFORMANT Estella Johnson (Niece)	
				ADDRESS 3405 Holmes Ave.	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-30-68 to 9-2-68, that (I) (we) last saw the deceased alive on 9-2-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M T Kook				23B. DATE SIGNED 9-3-68	
23C. PHYSICIAN'S NAME (Type) MIN TA KOOK				23D. ADDRESS Provident Hospital 1514 Division Street - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Philip E. Jackson		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	



NOT A MEDICAL EXAMINER'S CASE - SPITZ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9059 CERTIFICATE OF DEATH

REG. NO. 68- 9059

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EPKINS, EARL		2. DATE AND HOUR OF DEATH 2 PM 9-3-68		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSP BALTIMORE MD-21205				A. STATE MD		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES	
E. STREET AND NUMBER 2430 GUILFORD AVE.							
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-29	9. AGE (In years last birthday) 39	If Under 1 Yr. Months; Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DEATSVILLE A/A		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EUGENE EPKINS				14. MOTHER'S MAIDEN NAME ARIE KNIGHT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korea		16. SOCIAL SECURITY NO.		17. INFORMANT Naamie Epkin 5121 Norwalk Ln		ADDRESS	
18. 395.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) EXSANGUINATING HEMORRHAGE 1 HR.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RUPTURED AORTOTOMY 1 HR.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. POST-OPERATIVE AORTIC VALVE REPLACEMENT FOR AORTIC INSUFFICIENCY 1 HR.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 421.1 II CIRRHOSIS OF LIVER							
19A. DATE OF OPERATION 1 9/3/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC INSUFFICIENCY		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 9/3/68 to 9/3/68 , that (I) <u>(we)</u> last saw the deceased alive on 9/3/68 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.							
23A. SIGNATURE Gordon F. Murray M.D.				23B. DATE SIGNED 9/3/68		23C. PHYSICIAN'S NAME (Type) Gordon F. Murray, M.D.	
23D. ADDRESS The Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/8/68		24C. NAME OF CEMETERY or CREMATORY St James Bapt		24D. LOCATION (City, town, or county) (State) DEATSVILLE A/A	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Thurman & Angus 638 N. G. Ave. St		ADDRESS	

22

8

7

4

to the following persons

to the following persons

to the following persons

to the following persons

to the following persons

to the following persons

1/2

1/2

1/2

1/2

1/2

to the following persons

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9060

BIRTH NO. 62-2445

REG. NO.

1. NAME OF DECEASED (Type or Print) EMMANUEL DAVIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 2, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 2, 1968 11:51A.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 1-31-62		10. AGE (In years lost birthday) 6 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balt. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LESTER DANIELS		14. MOTHER'S MAIDEN NAME MAXINE ALSTON	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH 746.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Endocardial Fibroelastosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 754.4		21. AUTOPSY? (Yes or No) Yes	
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/3/68	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/6/68	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town or county) (State) D.A. County Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR John E. Taylor	
25C. FUNERAL DIRECTOR Joseph P. Rock		ADDRESS 1304 N. Central Ave	

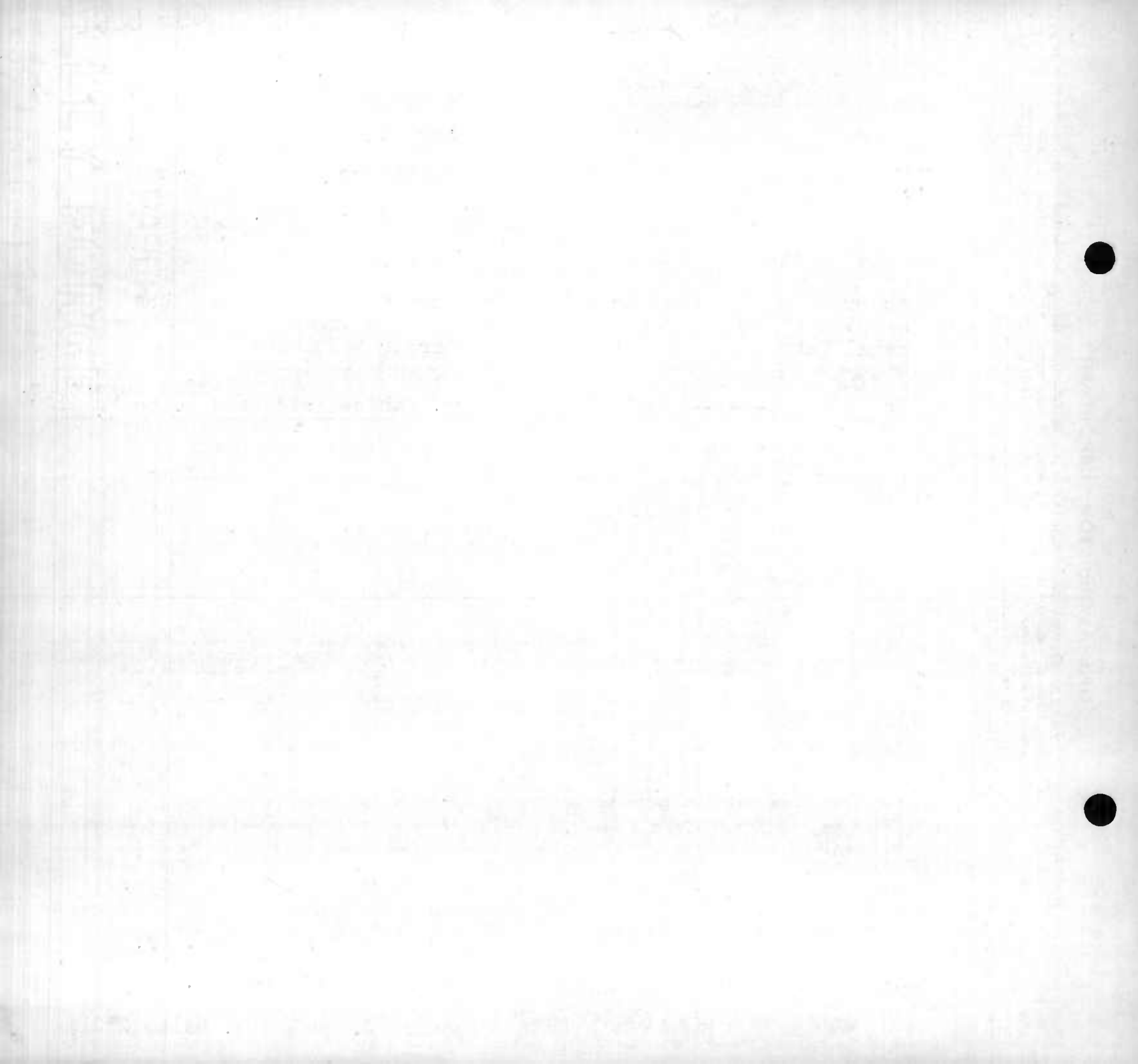
WALLACE GORDON

W. G. Gordon

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9061
68- 9061				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mildred M. Slater</i>		2. DATE AND HOUR OF DEATH <i>9-5-68 16²⁵ A.M.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <i>3306 Rosekemp Ave.</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/13/1901</i>	9. AGE (In years last birthday) <i>67</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>High School</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Samuel Kahn</i>		
14. MOTHER'S MAIDEN NAME <i>Margaret Tubman</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>219420562</i>		17. INFORMANT <i>Mrs. Janice Friedman- Balto Md 21209</i>		
18. <i>156.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Malignant Ascites</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Carcinoma of gall bladder</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) <i>Carcinoma of gall bladder</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. <i>155.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>8/25/68</i> 19 to <i>9/5/68</i> 19 that (I) (we) last saw the deceased alive on <i>9/5/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Cham-pi-lee</i>		23B. DATE SIGNED <i>9/5/68</i>		23C. PHYSICIAN'S NAME (Type) <i>DR. YING-SER CHAN</i>
23D. ADDRESS <i>Mercy Hospital, Balto. Md.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		
24B. DATE <i>9/9/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto 21214</i>



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9062

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH KENT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 3 68 11:45p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour September 3, 1968 11:45 p	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9/26/68		10. AGE (In years lost birthday) 75	
11. BIRTHPLACE (State or foreign country) New York, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Own Home	
15. MOTHER'S MAIDEN NAME Elizabeth Rigger		13. FATHER'S NAME Peter Ranieri	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-09-0036	
18. INFORMANT Charles H. Kent		ADDRESS 400 Ilchester Ave.	
19. 410.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21. AUTOPSY? (Yes or No) YES	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 2		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type) Edward F. Wilson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/7/1968	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	

• *Journal of Management Education* 32(10):1039-1050

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9063 CERTIFICATE OF DEATH
REG. NO. 68- 9063

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA MARGARET MUELLER		2. DATE AND HOUR OF DEATH SEPT 3, 1968 11:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TEACHER		10B. KIND OF BUSINESS OR INDUSTRY INTERIOR DESIGNING		8. DATE OF BIRTH MARCH 25, 1895 9. AGE (In years last birthday) 73	
13. FATHER'S NAME JOHN P. MUELLER		14. MOTHER'S MAIDEN NAME ANNA C. HESS		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-377172		12. CITIZEN OF WHAT COUNTRY? UNITED STATES A.	
17. INFORMANT CHARLES H. MUELLER		ADDRESS RIVER ROAD 18938 NEW HOPE PA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. 193.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA 1 mo.		19. 193.9 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). RECURRENT GLIOBLASTOMA 18 mos.		20. 193.9 II DUE TO, OR AS A CONSEQUENCE OF: EFW 3 mos.	
19A. DATE OF OPERATION 6/9/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED application of traction for hip		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? 3700 N. Charles St.	
21D. TIME OF INJURY (APPROX.) May 23 '68		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pt. fell (had hemiparesis)	
22. I certify that (I) <u>this hospital</u> attended the deceased from JUNE 7 1968 to SEPT 3 1968 , that (I) <u>we</u> last saw the deceased alive on 19 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. It (We) (did) not view the body after death.					
23A. SIGNATURE Ricardo Salvia				23B. DATE SIGNED SEPT. 3, 1968	
23C. PHYSICIAN'S NAME (Type) RICARDO SALVIA				23D. ADDRESS U.D. UNION MEMORIAL HOSPITAL, BALTIMORE, U.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9/9/1968		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore Md.		25A. DATE RECEIVED BY HEALTH DEPT. SEP 5 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto. 12, Md.			

UNITED STATES MARINE CORPS

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

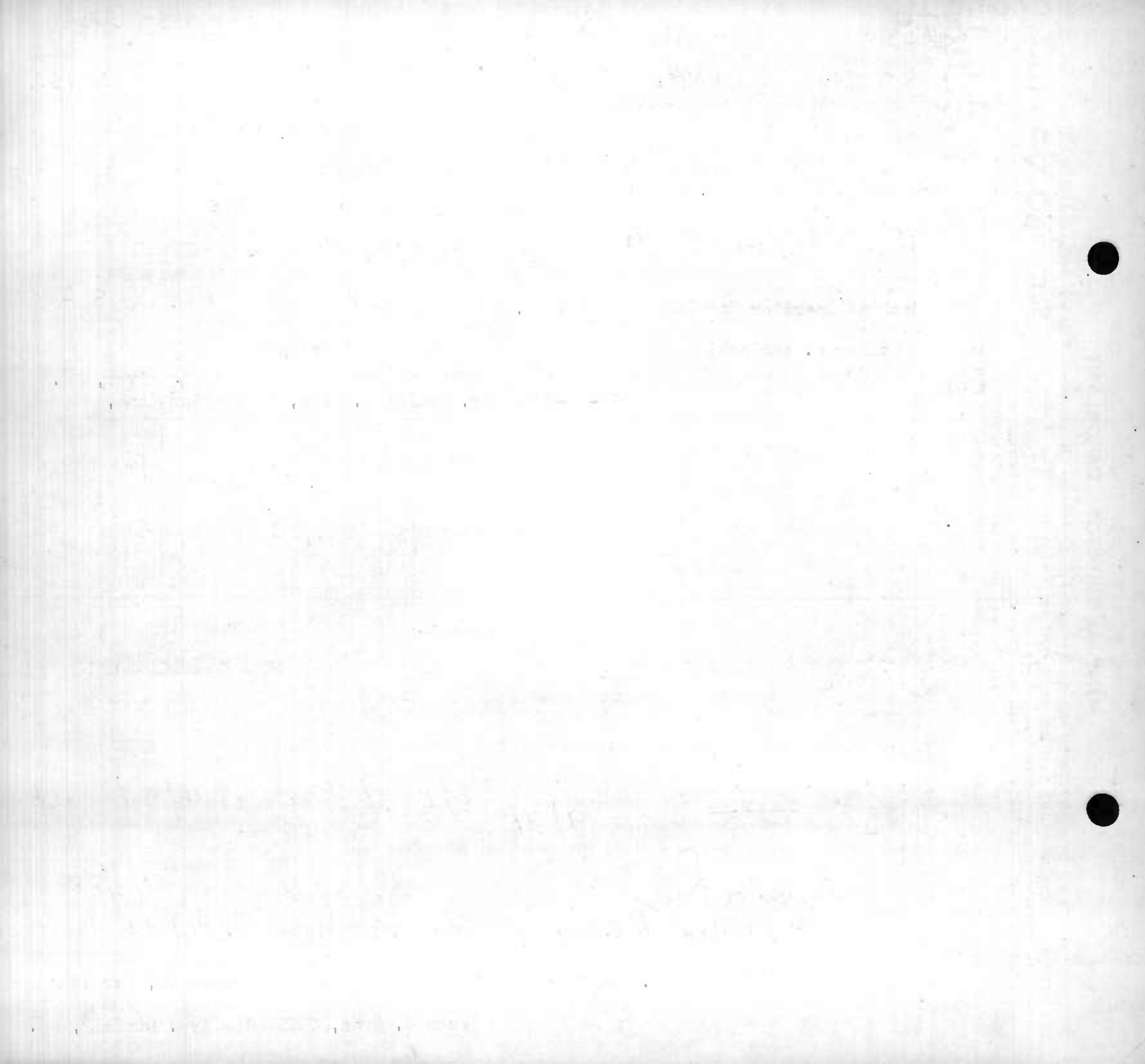
RECEIVED

RECEIVED

RECEIVED

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9064
J-212		68- 9064		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MRS. BERNICE JACOBS		
2. DATE AND HOUR OF DEATH 9/3/68		8:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 21220 Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL BALTIMORE-31		C. CITY OR TOWN Middle River D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 26 GENTIAN LANE
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/22
9. AGE (In years last birthday) 45		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		11. BIRTHPLACE (State or foreign country) M.D. Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator Maryland Clothing Co.		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Walter F. Lubinski		14. MOTHER'S MAIDEN NAME Theresa Miedzinski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-16-3950		17. INFORMANT (Son) Middle River, Md. Mr. Daniel A. Game, 26 Gentian Lane,
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.) ANTCEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma Lungs (B) Carcinoma Breast DUE TO, OR AS A CONSEQUENCE OF: (C) None		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few weeks (3) Several years
19A. DATE OF OPERATION 2, None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9/27/1968 to 9/31/1968 , that (I) (we) last saw the deceased alive on 9/31/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Krishna Reddy		23B. DATE SIGNED 9/3/68		23C. PHYSICIAN'S NAME (Type) KRISHNA REDDY
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/68		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
K-460		68-9065 CERTIFICATE OF DEATH				REG. NO. 68-9065			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENRY C. KOEHLER				2. DATE AND HOUR OF DEATH 9/3/68 2:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GEN. HOSPITAL Maryland General Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore			
						C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
						E. STREET AND NUMBER 843 LOALAN AVE			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/24		9. AGE (In years lost birthday) 44		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10B. KIND OF BUSINESS OR INDUSTRY Pemco (Glidden Co.)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John KOEHLER						14. MOTHER'S MAIDEN NAME Margaret BRANDT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 246-16-1542		17. INFORMANT (Wife) ENLA I. KOEHLER ADDRESS Dundalk, Md. 21222 843 Loalan Ave.					
18. 492 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIORESPIRATORY FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: COR PULMONALE, SEVERELY DECOMPENSATED (B) DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIOSIS (SILICOSIS) (C) PULMONARY EMPHYSEMA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 527.1 II									
19A. DATE OF OPERATION 2/27/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9/3/68 1:15 PM to 9/3/68 2:45 PM , that (I) (we) last saw the deceased alive on 9/3/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. M. De los Santos Jr., M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 9/3/68			
23C. PHYSICIAN'S NAME (Type) E. M. De los Santos Jr., M.D.						23D. ADDRESS 1154			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.					

Sub. Matter: 3/2

3/2/24

3/2/24

3/2/24

3/2/24

3/2/24

3/2/24

3/2/24

3/2/24

3/2/24

68- 9066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9066

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Marion G. Smiley (Ruppert)

DATE AND HOUR OF DEATH

3 05 AM Sept 2, 1968

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1235 ARMSTEAD WAY

21205

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

6-3-94

9. AGE (In years
last birthday)

74

If Under 1 Yr.
Months

Days

If Under 24 Hrs.
Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Robindale Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ROBERT ANDREE

14. MOTHER'S MAIDEN NAME

MARGARET CHISHOLM

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-22-8445

17. INFORMANT

RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD

ADDRESS

21224

18. 23-0.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Lactic acidosis

DUE TO, OR AS A CONSEQUENCE OF:

1 wk.

(B) Diabetes mellitus

DUE TO, OR AS A CONSEQUENCE OF:

8 yrs

(C) _____

260X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Liver necrosis

19A. DATE OF OPERATION

2 none

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED

IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐

Work

Not While ☐

At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 25 19 68 to Sept 2 19 68
that (I) (we) last saw the deceased alive on Sept 1 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Riley MD

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Sept 2, 1968

23C. PHYSICIAN'S
NAME (Type)

David J. Riley MD

DEGREE

23D. ADDRESS

4940 Eastern Ave, Balto Md 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/4/68

24C. NAME OF CEMETERY or CREMATORY

Mt. Carmel Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 6 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9067	
<div style="display: flex; justify-content: space-between;"> C-200 68- 9067 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Joseph C. Cook			2. DATE AND HOUR OF DEATH Aug. 31, 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 320 S. Mount Olivet Lane			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 320 S. Mount Olivet Lane		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1895	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Francis Cook		
14. MOTHER'S MAIDEN NAME Mary M. Eurick			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1918		
16. SOCIAL SECURITY NO.			17. INFORMANT Balto. Md. Mrs. Margaret M. Cook 320 S. Mount Olivet Lane		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. A.S.C.V.D.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/20/11		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1, 1960 to Aug 31, 1968 , that (I) (we) last saw the deceased alive on Aug 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. C. POUND			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) J. C. POUND			23D. ADDRESS 3320 Frederick Ave Balto Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 5, 1968		24C. NAME OF CEMETERY or CREMATORY Loudon National Cem	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR P. L. H. 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave Balto. Md.	

George Washington

1776

1776

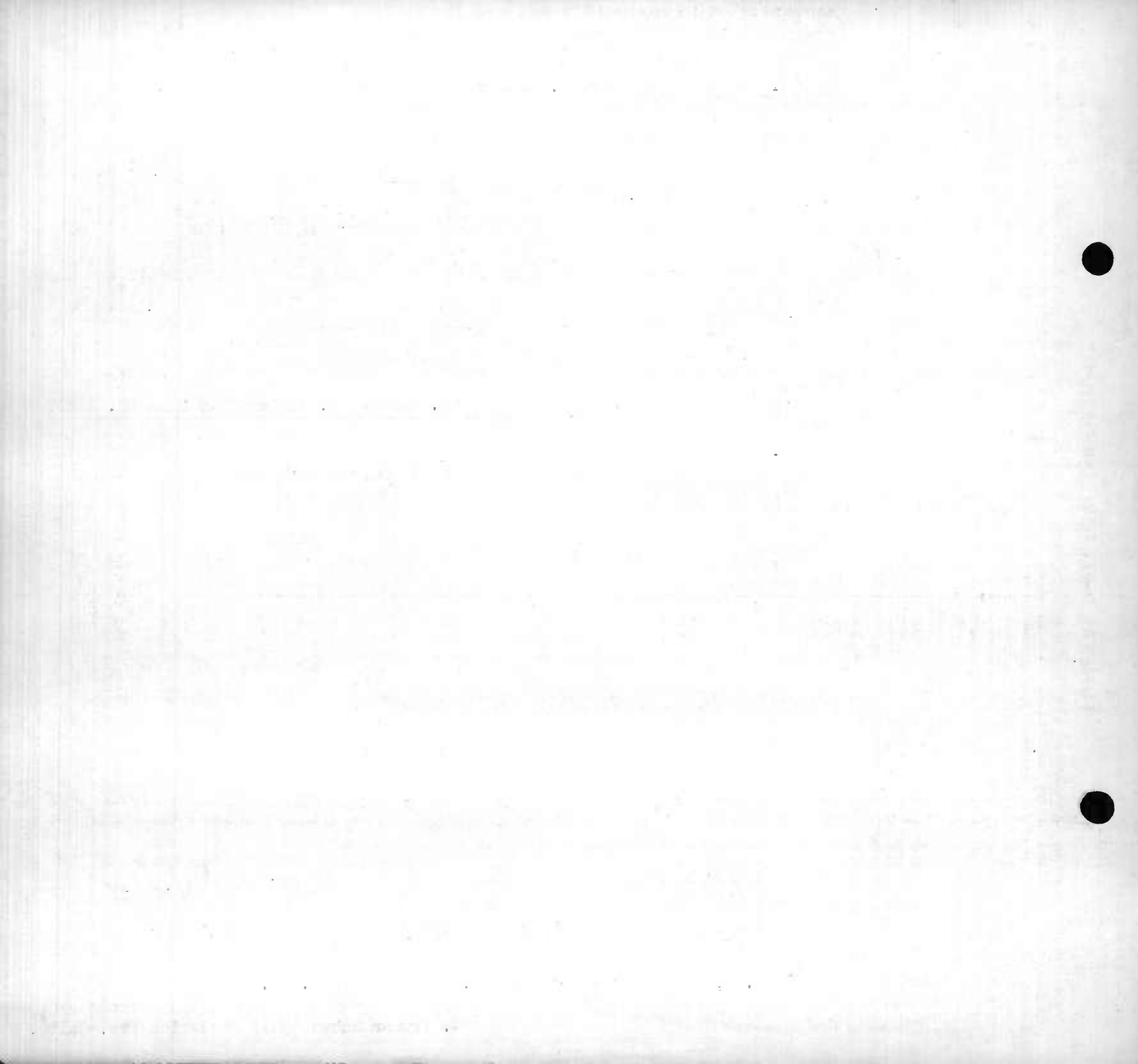
1776

1776

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-460		68-9068		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9068	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Miller Olive S (Olive S. Miller)		9.2.68 3:22 Pm		P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
36 Franklin Square hospital				Maryland city			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				249 Mc Curley St			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7.15.83	85			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				OHIO		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
--- TUDOR				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		216308322		Mr. Ambrose O. Miller 2816 Rona Rd. 21207			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C.V.A. & Possible M.I. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8.18.1968 to 9.2.1968, that (I) (we) last saw the deceased alive on 9.2.1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
M. Afzal						9.2.68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M. AFZAL				Franklin Sq. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Sept. 5, 1968		New Cathedral Cem.		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 6 1968		R. J. ...		G. Truman Schwab		3512 Frederick Ave. Balto.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 9069		REG. NO. 68- 9069	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 13-436 68- 9069 CERTIFICATE OF DEATH </div>							
1. NAME OF DECEASED (Type or Print) EFFIE S. BALDERSON				2. DATE AND HOUR OF DEATH SEPT 2, 1968 10.15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 814 Unetta Avenue Baltimore, Maryland 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 814 Unetta Avenue			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-22-1880 9. AGE (In years last birthday) 87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William B. Rowe			
14. MOTHER'S MAIDEN NAME Sarah				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Mr. E. Lewis Balderson, 814 Unetta Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 I CORONARY THROMBOSIS (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC C.V. Disease 10 YEARS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II				20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from AUG 30 1968 to SEPT 3 1968 , that (I) (we) last saw the deceased alive on SEPT 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John F. Coolahan M.D.				23B. DATE SIGNED 9/2/68		23C. PHYSICIAN'S NAME (Type) Dr. John F. Coolahan	
23D. ADDRESS 4201 WILKENS AVE - 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-5-1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

GERMANY THRONES

ASTORIA ASTORIA C.V. BUREAU 11 1942

NO

SEPT 1 1942

X

John H. Cushman

4211 WILKINS AVE - 2124

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9070	
7-236 68- 9070		CERTIFICATE OF DEATH			
BIRTH NO. 68-76681					
1. NAME OF DECEASED (Type or Print)		FOSTER, BABY GIRL		2. DATE AND HOUR OF DEATH SEPTEMBER 2, 1968 1:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 209-B PRESTON COURT 21228			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/68	9. AGE (In years lost birthday) 2	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME E. ROBERT FOSTER		14. MOTHER'S MAIDEN NAME JEAN NEWELL FOSTER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. 750.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Trachea - Esophageal DUE TO, OR AS A CONSEQUENCE OF: (B) Fistula & Prematurity DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 756.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 31 19 68 to SEPTEMBER 2 19 68, that (I) (we) last saw the deceased alive on SEPTEMBER 2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. de la Cruz - Alonso		23B. DATE SIGNED 9/2/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS ST. AGNES HOSP; CATON & WILKENS AVES.		BALTO, MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-4-1968		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION Ritchie Hwy., Glen Burnie, Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 6 1968		24F. NAME OF REGISTRAR Robert E. Hubbard	
24G. FUNERAL DIRECTOR Howard H. Hubbard		24H. ADDRESS 4107 Wilkens Avenue			

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9071	
K-260		68- 9071		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KAISER, BLANCHE VERONICA		SEPT 2 1968		9:00P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
ST AGNES HOSP. CATON & WILKENS AVE BALTIMORE, MARYLAND 21229		MARYLAND Baltimore			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		305 N. Beechwood Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	08 16 82	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Bernard Fallon		MAIRIE FALLON Ella (Unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				ST AGNES RECORDS-CATON & WILKENS AVE	
18. <u>440.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>Atherosclerosis</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>AUGUST 31</u> 19 <u>68</u> to <u>SEPT 2</u> 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>SEPT 2</u> 19 <u>68</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				09 02 68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
SALVADOR QUIROZ		ST AGNES HOSP. BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	9-5-1968	New Cathedral Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 6 1968				Howard H. Hubbard, 4107 Wilkens Ave. 21229	

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

0000

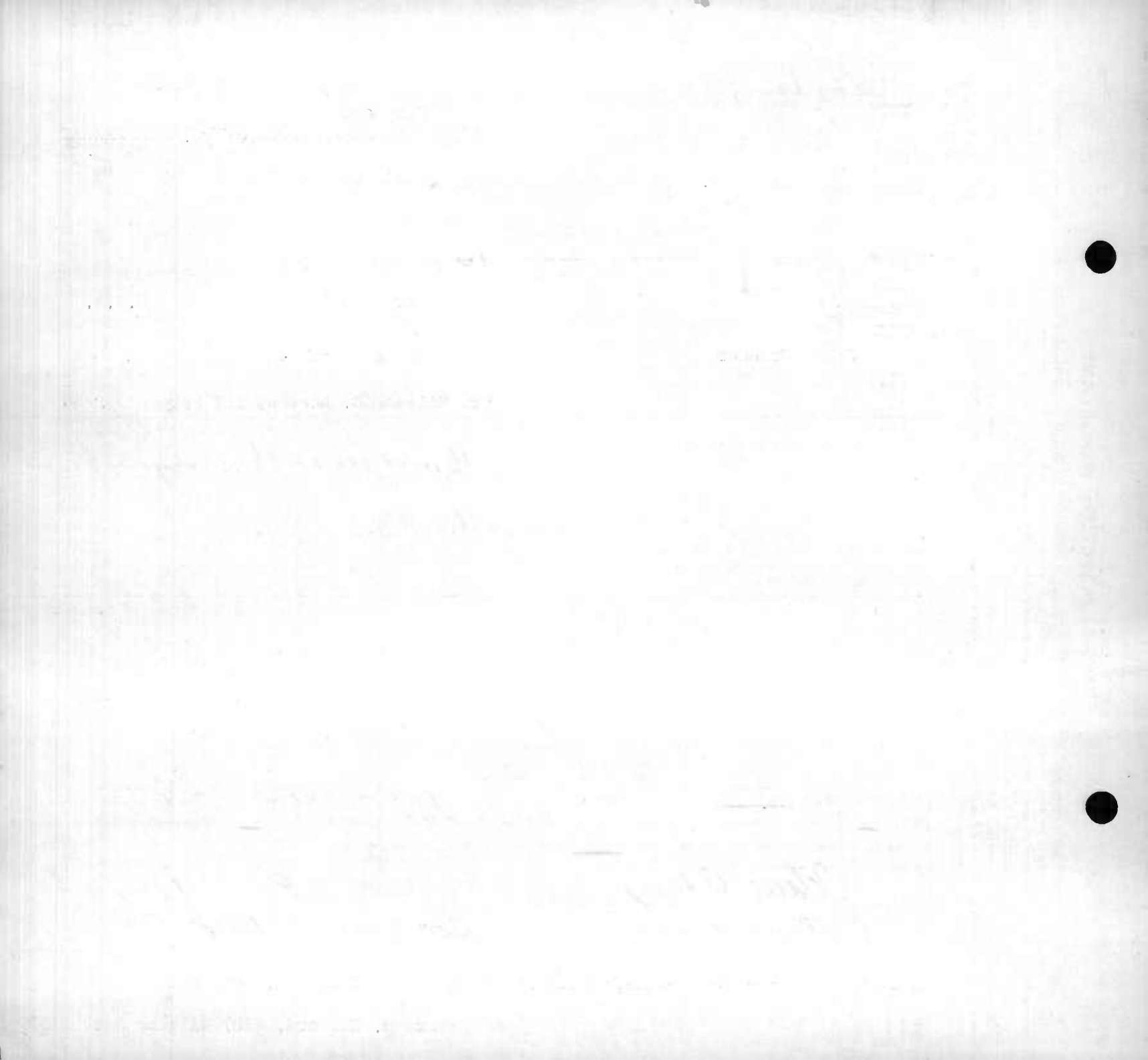
0000

0000

0000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B



W-452

68- 9073 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9073

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ANDREW WILLIAMS				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 3 68 1:40 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 822 Harlem Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour September 3 1968 1:40 p.m.			
6. SEX Male				7. RACE Colored		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-25-17				10. AGE (In years last birthday) 50		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Wm. Williams		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto.	
15. MOTHER'S MAIDEN NAME Loudonis Mosley				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO. 217140197				18. INFORMANT Viola Neal			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II				20. DATE OF OPERATION 2			
21. AUTOPSY? (Yes or No) YES				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-7-68			
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.				24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR Kelson F.H.				25D. ADDRESS 1348 Calhoun St.			

100-100

100-100

WILLIAM H. COLE
100-100

B-200 68- 9074

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9074

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILEY Herbert BASS

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ September 2, 1968 4:40 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour
September 2, 1968 4:40 P.M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

6-4-00

10. AGE (In years lost birthday)

68

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1102 Riggs Avenue

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Herbert Bass Sr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sylentia Arrington

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

216102126

18. INFORMANT

Minnie Bass

ADDRESS

same

19.

E 816.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Multiple Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E 823.4 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Edmondson Ave. E. of Hilton St.

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

9/2/68 3:55 P.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR? (driver) - skidded - jumped center strip - into opposite lane - was struck broadside.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/3/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-6-68

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State)

Arbutus Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 6 1968

25B. NAME OF REGISTRAR

R. E. F. Bailey

25C. FUNERAL DIRECTOR

V.R. Bailey

ADDRESS

1348 Calhoun St.

— *James A. [unclear]*

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9075

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD L. ROBERTS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 3, 1968 1:08 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 13 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 3, 1968 1:08 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-03			
6. SEX male	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH June 3, 1918		10. AGE (In years lost birthday) 50	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY Cat Paw Rubber Co. Lula	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes 4/24/45-1/2/47		17. SOCIAL SECURITY NO. Violet Roberts 2316 Ruskins Ave.	
19. E 965 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot Wound of Head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) (home)?	
22D. TIME OF INJURY (APPROX.) 9/3/68 1:00 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 608 Chieraton Rd.		22F. HOW DID INJURY OCCUR? subj. was shot in head	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/3/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-68	
24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Kelson F. H.	
25C. FUNERAL DIRECTOR 1348 N. Calhoun St.		ADDRESS	

James L. Kirk

68- 9076

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9076

BIRTH NO.

REG. NO.

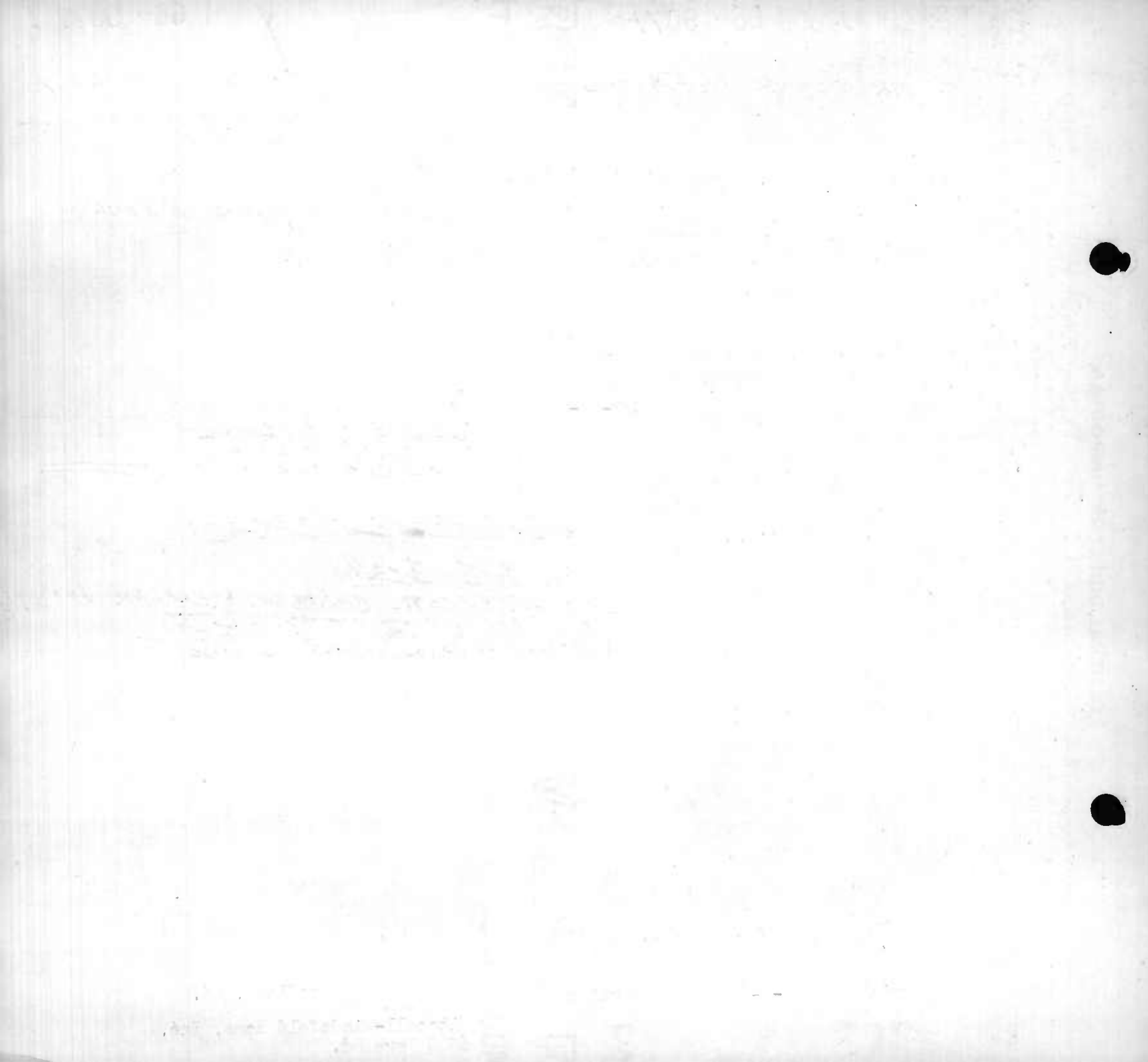
1. NAME OF DECEASED (Type or Print) WILLIAM ENOCH WILSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Police Boat Intrepid		3. DATE PRONOUNCED DEAD Month Day Year Hour July 28, 1968 11:10 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-02			
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 00	10. AGE (In years lost birthday) 40	E. STREET AND NUMBER 1104 W. Lexington Street	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. E 910.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) Found in water, presumed drowned		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E 929.8 II			
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Found in water at foot of Montford St.
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ?	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell or jumped in water
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. DATE SIGNED August 6, 1968 EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE SEP 6 1968	24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968	25B. NAME OF REGISTRAR Robert E. [Signature]	25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

Chas. J. F.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

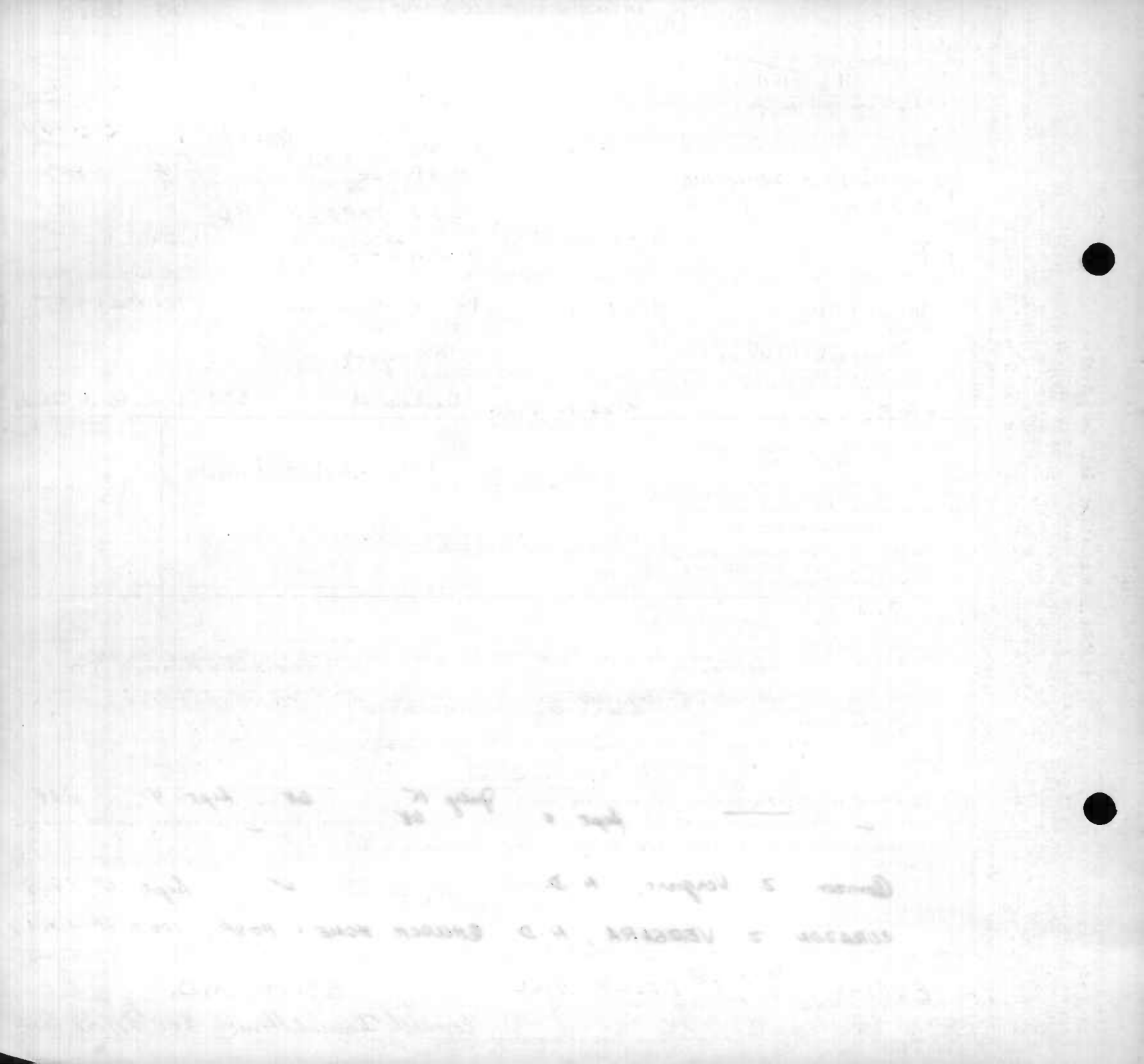
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) MR. GROVER McFARLAND		2. DATE AND HOUR OF DEATH 9/5/68 12:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp.		A. STATE MD		B. COUNTY 7513 Irigouois Avenue	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/29/92		9. AGE (in years lost birthday) 76		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OHIO	
13. FATHER'S NAME LEVI McFARLAND		14. MOTHER'S MAIDEN NAME Unknown?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 287-03-5307 A		17. INFORMANT MRS BETTIE FURR	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMPHYSEMA		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIO-SCLEROTIC CEREBROVASCULAR DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO-SCLEROTIC CEREBROVASCULAR DISEASE		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ARTERIO-SCLEROTIC CEREBROVASCULAR DISEASE			
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Debra C. Gomez, M.D.		23B. DATE SIGNED 9-5-68		23C. PHYSICIAN'S NAME (Type) Debra C. Gomez, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-68		24C. NAME OF CEMETERY or CREMATORY Lorraine	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		25D. ADDRESS 6500 York Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-520		68- 9078		BALTIMORE CITY HEALTH DEPARTMENT		68- 9078	
CERTIFICATE OF DEATH				REG. NO. X			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. Genevieve M. Panuska		2. DATE AND HOUR OF DEATH 9/14/68		7 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home Hospital Baltimore Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO Co 53-00 C. CITY OR TOWN Essex D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 337 TORMER RD			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-4-13		9. AGE (In years last birthday) 55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY House-wife		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Michael Mullin				14. MOTHER'S MAIDEN NAME Margret ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) NAK		16. SOCIAL SECURITY NO. 058-10-9520		17. INFORMANT Husband		ADDRESS 337 Tormer Road. 21221	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal failure Anura (B) Carcinoma Cervix; - Uremia DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 months	
171X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 15 19 68 to Sept. 4 19 68 , that (I) (we) last saw the deceased alive on Sept. 4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Corazon Z. Vergara, M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 4, 1968	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D. DEGREE				23D. ADDRESS CHURCH HOME HOSP., 100 N. BROADWAY			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/7/68		24C. NAME OF CEMETERY or CREMATORY HOLLY HILL		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Connolly Funeral Home		ADDRESS 300 More Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9079
K-460 68- 9079		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Charlotte E. Koller		2. DATE AND HOUR OF DEATH Sept. 1, 1968 6²⁹ P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 91 Keswick 700 W. 40th Street Balto., Md. 21211		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 28, 1886		9. AGE (In years last birthday) 81		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James J. Koller		
14. MOTHER'S MAIDEN NAME Elizabeth Bressler		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		
16. SOCIAL SECURITY NO. 214-24-7659		17. INFORMANT Records, Keswick Fairchildren		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Parkinson's Disease		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		13 years		
19A. DATE OF OPERATION 4-20-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from October 11, 1968 to September 1, 1968 , that (I) (we) last saw the deceased alive on September 1, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE W. Grafton Hersperger		23B. DATE SIGNED September 2, 1968		23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-4-68		24C. NAME OF CEMETERY or CREMATORY Freedom
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 8 1968		
25B. NAME OF REGISTRAR R. E. E. Johnson		25C. FUNERAL DIRECTOR Arthur H. Wright		
25D. ADDRESS 100 W. 40th Street - Balto., Md. 21211		25E. ADDRESS 100 W. 40th Street - Balto., Md. 21211		

Room 404
2nd Floor
11 2nd St
St. Louis, Mo 63104

Female White

Companion

James L. Keller

Unknown

Mr. & Mrs. 61

Married

Elizabeth Brewer

on 11-22-55
James L. Keller
Room 404
2nd Floor
11 2nd St
St. Louis, Mo 63104

James L. Keller

James L. Keller

James L. Keller

James L. Keller

H-543

68- 9080

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9080

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WOODROW HAMILTON

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

September 4, 1968

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

September 4, 1968

7:10 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Oct. 13, 1913

10. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1609 S. Charles Street

11. BIRTHPLACE (State or foreign country)

Frederick, Md.

12. CITIZEN OF
WHAT COUNTRY?
U S A

13. FATHER'S NAME

William Hamilton

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Attendant

14B. KIND OF BUSINESS OR INDUSTRY

Service Station

15. MOTHER'S MAIDEN NAME

Florence Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Elsie A. Hamilton 1609 S. Charles St.

19. 412.4 I

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9 7 68

24C. NAME of CEMETERY or CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Brooklyn, A. A. Co. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 6 1968

25B. NAME OF REGISTRAR

Robert E. Fotherman

25C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave

WALTER
PATENT
OFFICE
JAN 27 1900
NEW YORK

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) EDWARD H. MILLER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 2, 1968 12:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Maryland Penitentiary		3. DATE PRONOUNCED DEAD Month Day Year Hour September 2, 1968 12:40 P.M.	
6. SEX male		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE MARYLAND B. COUNTY W. Virginia	
7. RACE white		C. CITY OR TOWN Weinton	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 3/29/1907		E. STREET AND NUMBER 115 Elmer Avenue	
10. AGE (In years last birthday) 61		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James William Miller	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		15. MOTHER'S MAIDEN NAME Bessie L. Valentine	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. Don't Know	
18. INFORMANT Mrs. Paul Wenrich		ADDRESS 901 Braddock Rd. Cumberland Md.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION 422.1 II		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/3/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/ 5/1968	
24C. NAME OF CEMETERY or CREMATORY Zion Memorial Park		24D. LOCATION (City, town, or county) (State) Near Cumberland, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Jankovic	
25C. FUNERAL DIRECTOR John J. Hafer, Jr.		ADDRESS 230 Balto Ave. Cumberland Md.	

WALLACE

James M. Wallace

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9082	
BIRTH NO.				1		
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		
JOHNSON, NILS ---				AUGUST 31, 1968 7:10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY		
ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229				MARYLAND 21871		
C. CITY OR TOWN				D. INSIDE CITY LIMITS?		
WESTOVER				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER						
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-08-12	55		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
FARMER		SELF EMPLOYED		SWEDEN		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		
NOT KNOW				NINA HAAKANNSSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
YES WAR 11						WILKENS & CATON AVES ST. AGNES RECORDS - BALTIMORE, MD. 21229
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hemorrhage, Intracerebral, Spontaneous Temporal lobe, Lt. 8-18-68		
(B) DUE TO, OR AS A CONSEQUENCE OF:						
(C) DUE TO, OR AS A CONSEQUENCE OF:						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
08/29/68		INTRACEREBRAL HEMATOMA		YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
NO						
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (X) (this hospital) attended the deceased from AUGUST 25, 1968 to AUGUST 31, 1968, that (X) (we) last saw the deceased alive on AUGUST 31, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.						
23A. SIGNATURE				23B. DATE SIGNED		
Romualdo P. Dator, M.D.				Sept. 1, 1968		
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		
ROMUALDO DATOR, M.D.				WILKENS & CATON AVES ST. AGNES HOSPITAL - BALTIMORE, MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or County) (State)
BURIAL		9/4/1968		BEECHWOOD MEMORIAL CEM.		PRINCESS ANNE, MD.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
SEP 6 1968		Levin R. Wilson		LEVIN R. WILSON PRINCESS ANNE, MD.		

113-100

AT JAMES HOSPITAL
WILKINS & CATON AVENUE
BALTIMORE, MD. 21205

DATE 10-07-10
RACE WHITE
STATUS SELF EMPLOYED
STAFFER

ST. AGITE RECORDS - BALTIMORE, MD. 21205
WILKINS & CATON AVENUE

NO
1 TRACKER/EPIDEMIOLOGICAL UNIT
YES

AUGUST 21, 1910
AUGUST 22, 1910
AUGUST 23, 1910
AUGUST 24, 1910
AUGUST 25, 1910
AUGUST 26, 1910
AUGUST 27, 1910
AUGUST 28, 1910
AUGUST 29, 1910
AUGUST 30, 1910
AUGUST 31, 1910

WILKINS & CATON AVENUE
BALTIMORE, MD. 21205

DAVID H. WILKINS

1
D-500 68- 9083 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68- 9083

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MICHAEL DUNN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 1 68 2:30 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION City Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour September 1, 1968 2:30 a. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto.	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 14 Mar 1949		10. AGE (In years lost birthday) 19		E. STREET AND NUMBER 3122 Baybriar Rd.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eddie H. Dunn	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		14B. KIND OF BUSINESS OR INDUSTRY Auto Sales and serv.		15. MOTHER'S MAIDEN NAME Marie H. Gray	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 215-52-4291		18. INFORMANT ADDRESS Eddie H. Dunn, 3122 Baybriar Rd. 21222	
19. E 815.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 815.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Rd.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Sollers Point Rd.	
22D. TIME OF INJURY (APPROX.) 9 1 68 2:02a		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject driver of motor cycle into tree	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED September 1, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4 Sept 1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md. 21222		25D. ADDRESS		25E. ADDRESS	

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

1953-54

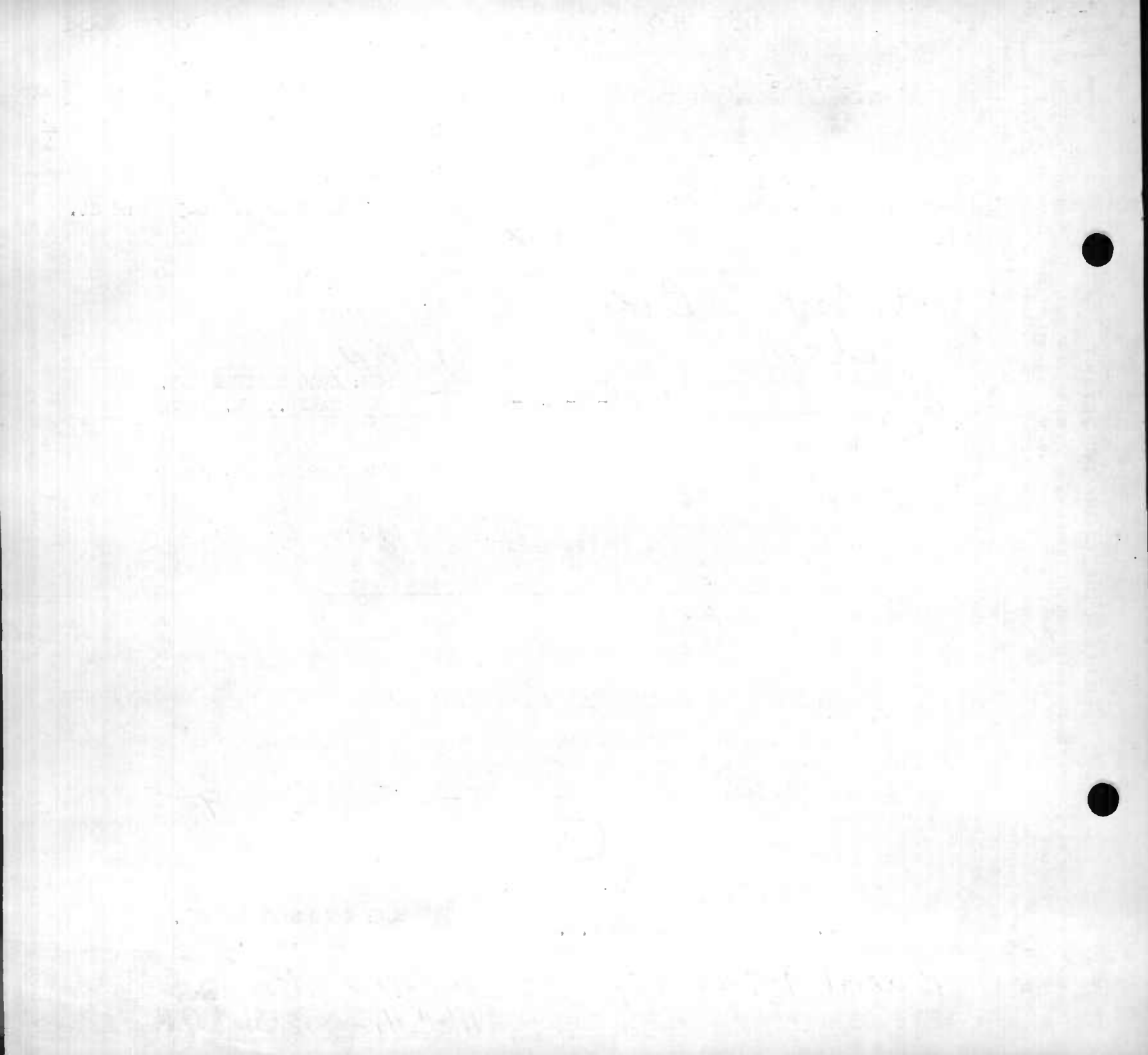
1953-54

1953-54

1953-54

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-53-96		68-9084		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9084	
G-162		68-9084		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		STEVE W. GARRICK		9-5-68		2:00 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1802 HUNTER PLACE 21224 623 Bond St.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-89	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Cook		
11. BIRTHPLACE (State or foreign country) Lithuania			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME UKN.			14. MOTHER'S MAIDEN NAME UKN.				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 497-07-6144-A		17. INFORMANT RECORDS: BCH: 4940 EASTERN AVE. BALTO., MD. 21224		
18. 299X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) urinary tract infection				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. organic brain syndrome							
19. 309X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-25-1968 to 9-5-1968, that (I) (we) last saw the deceased alive on 9-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Christopher Stucky M.D.				23B. DATE SIGNED 9-5-68			
23C. PHYSICIAN'S NAME (Type) R. CHRISTOPHER STUCKY M.D.				23D. ADDRESS BCH: 4940 EASTERN AVE. BALTO., MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-7-68		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Balto, 25, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert J. Taylor		25C. FUNERAL DIRECTOR McCully - 130 E. Fort Ave		25D. ADDRESS 21230	



W-200 68- 9085 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **68- 9085**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEONARD L. WESS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 2, 1968 8:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1035 Catharal Street		3. DATE PRONOUNCED DEAD Month Day Year September 2, 1968 8:50 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH FEB. 10, 1904		10. AGE (In years lost birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		14B. KIND OF BUSINESS OR INDUSTRY TRUCKING	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220-09-6033	
13. FATHER'S NAME HENRY J. WESS		15. MOTHER'S MAIDEN NAME ANNA MAE MULCAHY	
18. INFORMANT Charles H. Ward - 237 E. Melwood Bath		ADDRESS	

19. 412.41-250.9 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus		

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum, M.D.** M.D.
 EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **September 2, 1968**

24A. BURIAL CREMATION, REMOVAL (Specify) Buried	24B. DATE 9-5-68	24C. NAME OF CEMETERY or CREMATORY St. Peter's Cem.	24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Johnson	25C. FUNERAL DIRECTOR ADDRESS Foley-Corning & Son Catonsville Md.

300-50

300-50

300-50

THIS BOOK IS THE PROPERTY OF THE

WALTON COUNTY

LIBRARY

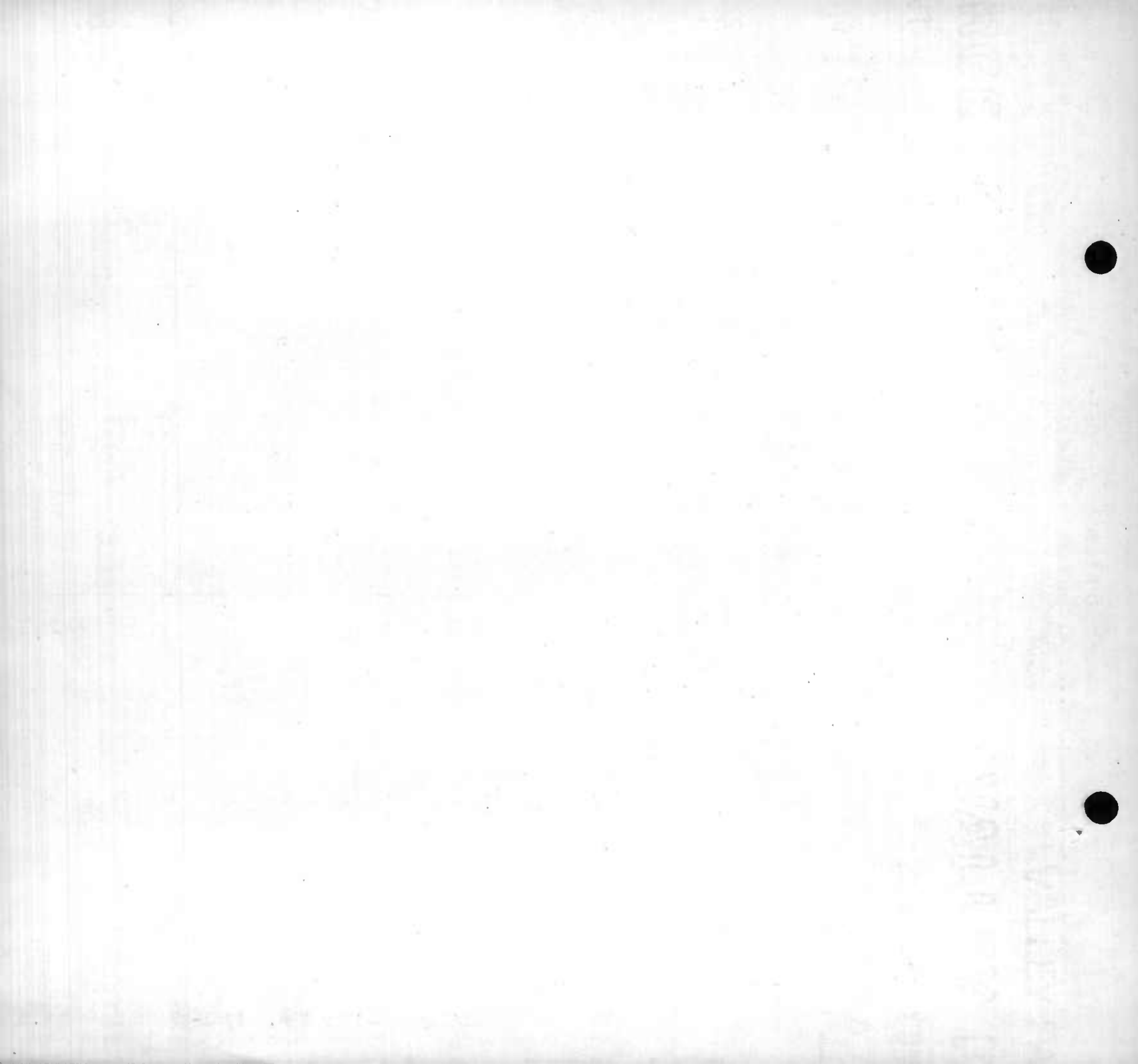
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-650		68- 9086		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 9086	
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) FREMEAU, MYRTLE Virginia					2. DATE AND HOUR OF DEATH September 1, 1968. 6 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL Co 52-00				
5. SEX Female 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH MAY 14, 1913 9. AGE (In years last birthday) 55 YRS.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.				
10B. KIND OF BUSINESS OR INDUSTRY —					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOSEPH LOWE					14. MOTHER'S MAIDEN NAME Fannie Browning				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 577-22-9926				
17. INFORMANT Harold Fremeau ADDRESS Same as Item 4.					18. CAUSE OF DEATH				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 332 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					(A) IMMEDIATE CAUSE Encephalomalacia, left cerebral hemisphere 1 week				
					(B) Cerebral thrombosis 1 week				
					(C) Healed myocardial infarction 2 1/2 years				
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) Yes					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from 8-30-68 19 to 9-1 1968, that (X) (we) last saw the deceased alive on 9-1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					23A. SIGNATURE Robert A. Pumphrey				
23B. DATE SIGNED 9-1-68					23C. PHYSICIAN'S NAME (Type) Benito Martinez				
23D. ADDRESS Bon Secours Hospital					24A. BURIAL CREMATION, REMOVAL (Specify) Burial				
24B. DATE 9-5-68					24C. NAME OF CEMETERY or CREMATORY Ft. Lincoln Cemetery				
24D. LOCATION (City, town, or county) (State) Bladensburg, Maryland					25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968				
25B. NAME OF REGISTRAR Robert A. Pumphrey					25C. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

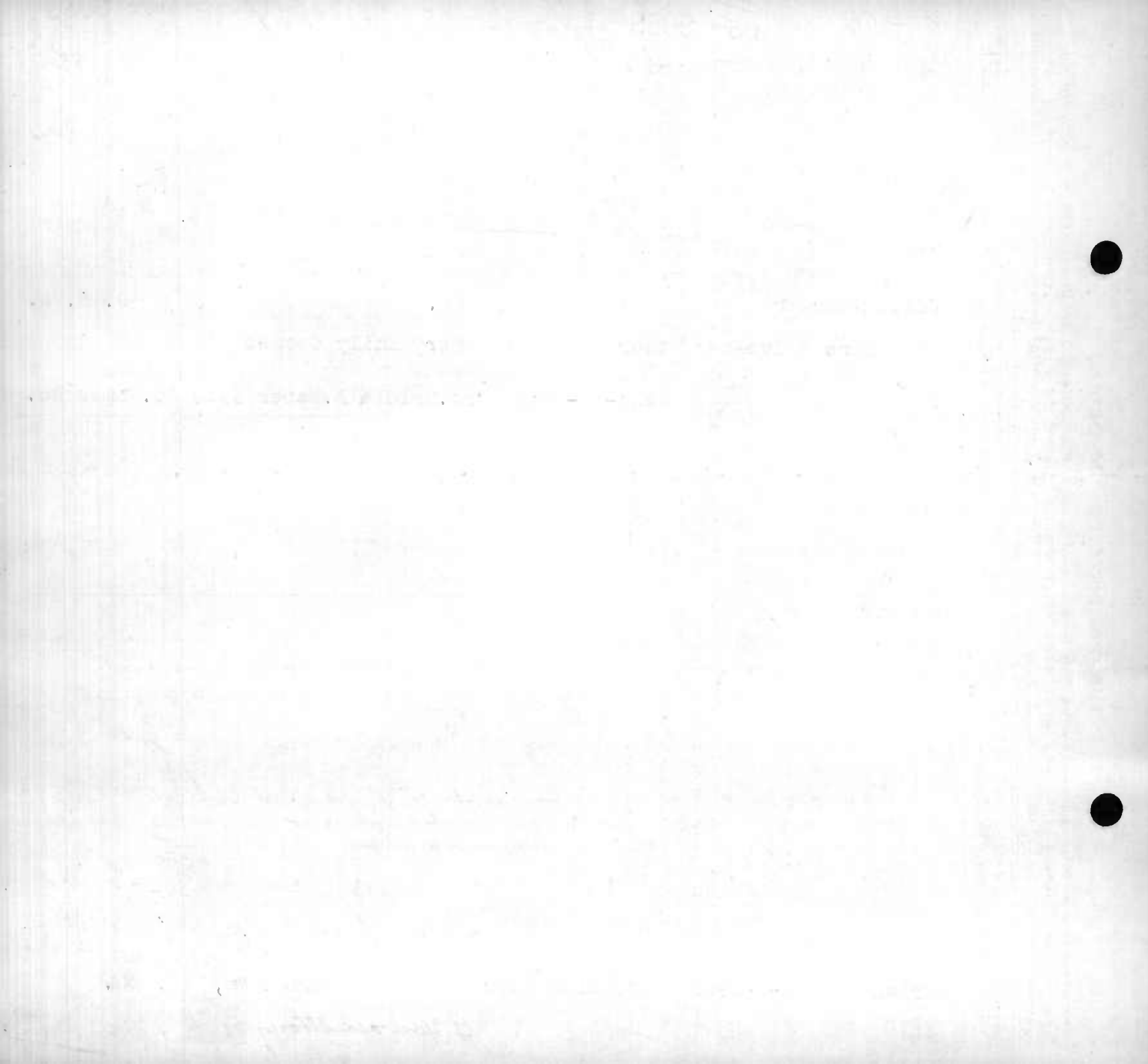
H-652		68- 9087		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9087	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Agnes C. Harrington</i>			
2. DATE AND HOUR OF DEATH <i>9-5-68</i> <i>12¹⁵</i> P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>310 S. Madeira Street</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-3-04</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Hill</i>				14. MOTHER'S MAIDEN NAME <i>Combs Nanny Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>JOSEPH HARRINGTON - HUSBAND - SAME</i>			
18. <i>452X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>BRONCHOPNEUMONIA</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>resected</i> (B) <i>Right corted aneurysm,</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Yema</i> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8-10 days</i>			
19. <i>452X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>BRAIN SWELLING</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>27 days</i>			
19A. DATE OF OPERATION <i>8-9-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Resected aneurysm</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (this hospital) attended the deceased from <i>July 30, 1968</i> to <i>Sept. 5, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 5, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Charles S. Harrison, M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-5-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHARLES S. HARRISON</i>				23D. ADDRESS <i>MARYLAND GENERAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-9-1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sacred Heart</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore County, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Seaborn</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Lilly & Zeiler Inc. 1901-07 Eastern Ave.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-160		68-9088		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. X		68-9088		
BIRTH NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) Theodore Edward Weber					9-4-68 10 ³⁵ A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Balto Gen Hosp 3001 Hanover St.					C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3524 St. James Rd										
5. SEX m	6. RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-07	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager			10B. KIND OF BUSINESS OR INDUSTRY Poca Cola		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Theodore Sylvester Weber			14. MOTHER'S MAIDEN NAME Mary Emily Coomes							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 216-07-2950		17. INFORMANT Mrs. Goldie A. Weber				ADDRESS 3524 St. James Rd.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Impetigo Infection ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Impetigo Infection (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.		
19A. DATE OF OPERATION 9-20-68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from Sept 4 19 68 to Sept 4 19 68 , that (1) (we) last saw the deceased alive on Sept 4 19 68 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.										
23A. SIGNATURE M. J. Elin					23B. DATE SIGNED Sept 4, '68					
23C. PHYSICIAN'S NAME (Type) M. J. Elin					23D. ADDRESS 8672 Liberty Rd - Randallstown, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-7-1968		24C. NAME of CEMETERY or CREMATORY Lorraine Park			24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968			25B. NAME OF REGISTRAR Robert E. Johnson			25C. FUNERAL DIRECTOR G. Howard Strong			ADDRESS North + Hilton Balto.	



5-435-68-9089

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-9089

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD M. SHELTON				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 3 68 4:25 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour September 3, 1968 4:25 p.m.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov. 28, 1909				10. AGE (In years lost birthday) 58		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Late John Shelton		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter	
15. MOTHER'S MAIDEN NAME Late Stella ?				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Country Meats		17. SOCIAL SECURITY NO. 314-10-0375	
18. INFORMANT Mrs. Harriette Shelton				19. ADDRESS 4643 Manordene Rd. Balto., Md.		20. CAUSE OF DEATH Fatty metamorphosis of the liver	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent causes				22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 5-81.0 II			
23A. DATE OF OPERATION				23B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
23C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				23D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
23E. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				23F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23G. HOW DID INJURY OCCUR?				23H. AUTOPSY? (Yes or No) YES			
24. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
25. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				26. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
27. DATE SIGNED September 4, 1968				28. DATE			
29. BURIAL CREMATION, REMOVAL (Specify) Cremation				30. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery			
31. LOCATION (City, town, or county) (State) Baltimore, Maryland				32. NAME OF REGISTRAR Witzke Fun. Dir., 4101 Edmondson Ave.			
33. DATE REC'D BY HEALTH DEPT. SEP 6 1968				34. FUNERAL DIRECTOR ADDRESS Witzke Fun. Dir., 4101 Edmondson Ave.			

65-2030

10-10-65

10-10-65

10-10-65

10-10-65

10-10-65

10-10-65

WALLACE P. HARRIS

10-10-65

68- 9090

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9090

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MONROE W. RUSSELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 1, 1968 11:40 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 1, 1968 11:40 P. M.	
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 7-26-98		10. AGE (In years last birthday) 70	11. BIRTHPLACE (State or foreign country) Fairfield, S.C.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James Russell	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Regina Lipsey	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 246-105130	
18. INFORMANT Margaret Gatewood		ADDRESS 2026 E. Eager St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injuries		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E900.0 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2009 E. Eager Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Sept. 1, 1968 7:30 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell while climbing steps	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED September 2, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-6-68	
24C. NAME of CEMETERY or CREMATORY St. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St.	

WALLLEY, J. D.

WALLLEY, J. D.

WALLLEY, J. D.

WALLLEY, J. D.

WALLLEY, J. D.

FUNERAL DIRECTOR: IMPORTANT

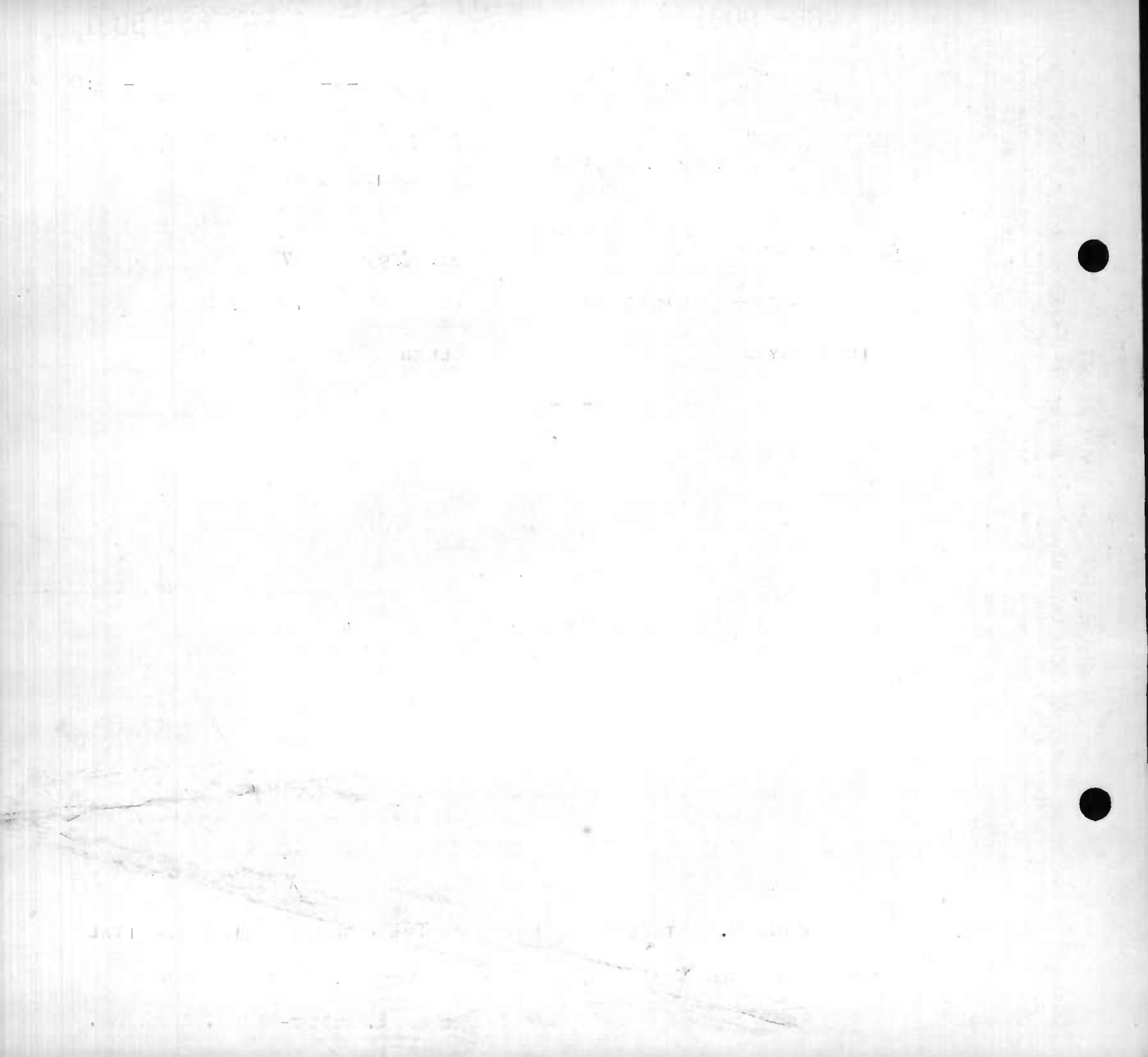
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9091

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9091

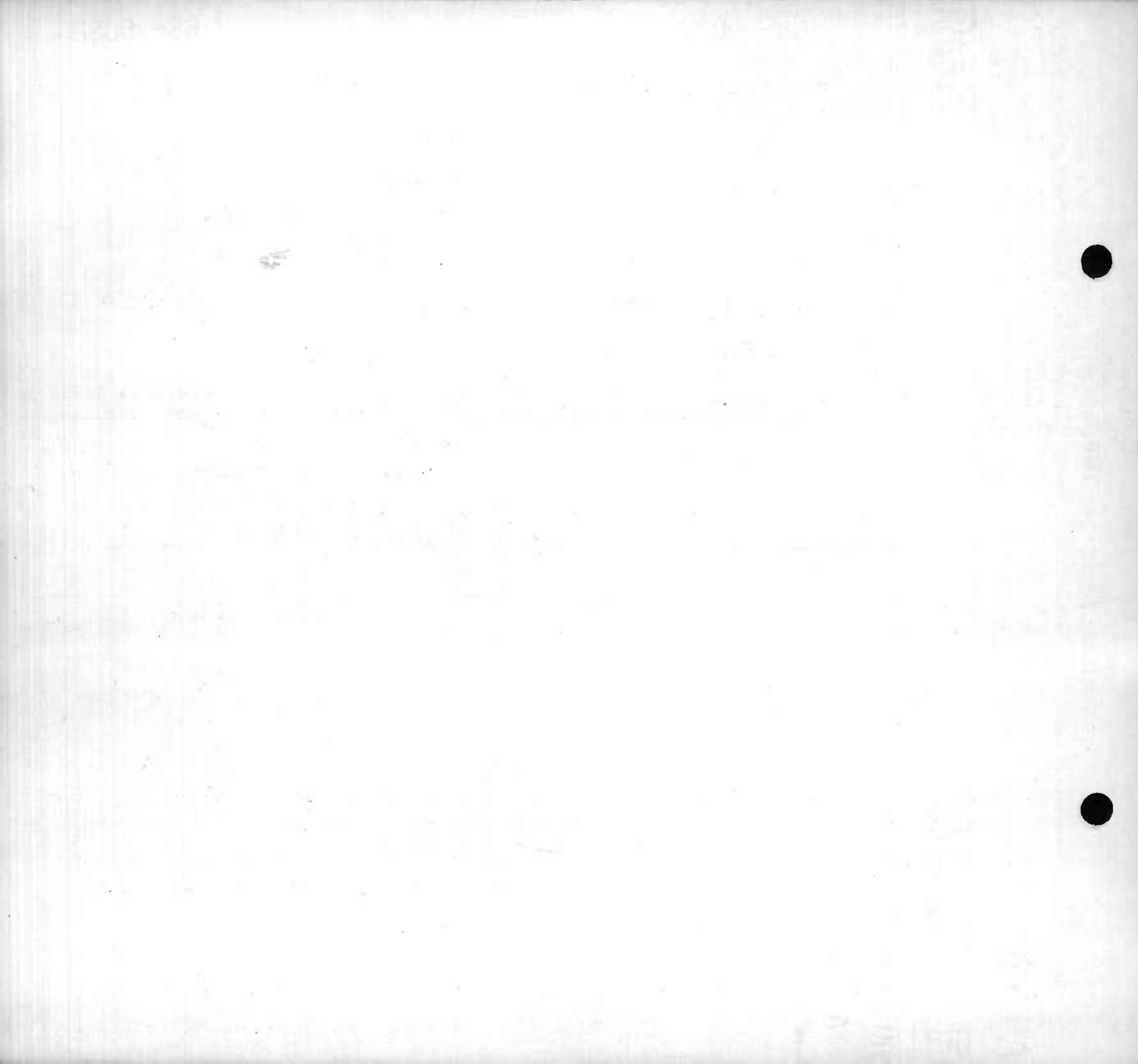
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John R. Hayes</u>		2. DATE AND HOUR OF DEATH <u>9-4-68</u> <u>9:00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 J. W. H. John Hopkins Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2417 Hamilton Ave</u>					
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/95</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Social Security</u>		11. BIRTHPLACE (State or foreign country) <u>Isle of Wight Co. Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>MILLS HAYES</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN Clemmons</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>219-42-6029M</u>		17. INFORMANT <u>Hospital sheet</u>	
18. <u>285101</u> DISEASE OR CONDITION LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hemoglobinosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>TRANSFUSIONS</u> <u>REFRACTORY ANEMIA</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> 19 <u>68</u> to <u>9/4</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/4</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John H. Stobo</u>		23B. DATE SIGNED <u>9/4/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>JOHN H. STOBO</u>		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/9/1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltz</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter-3035 W. North Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

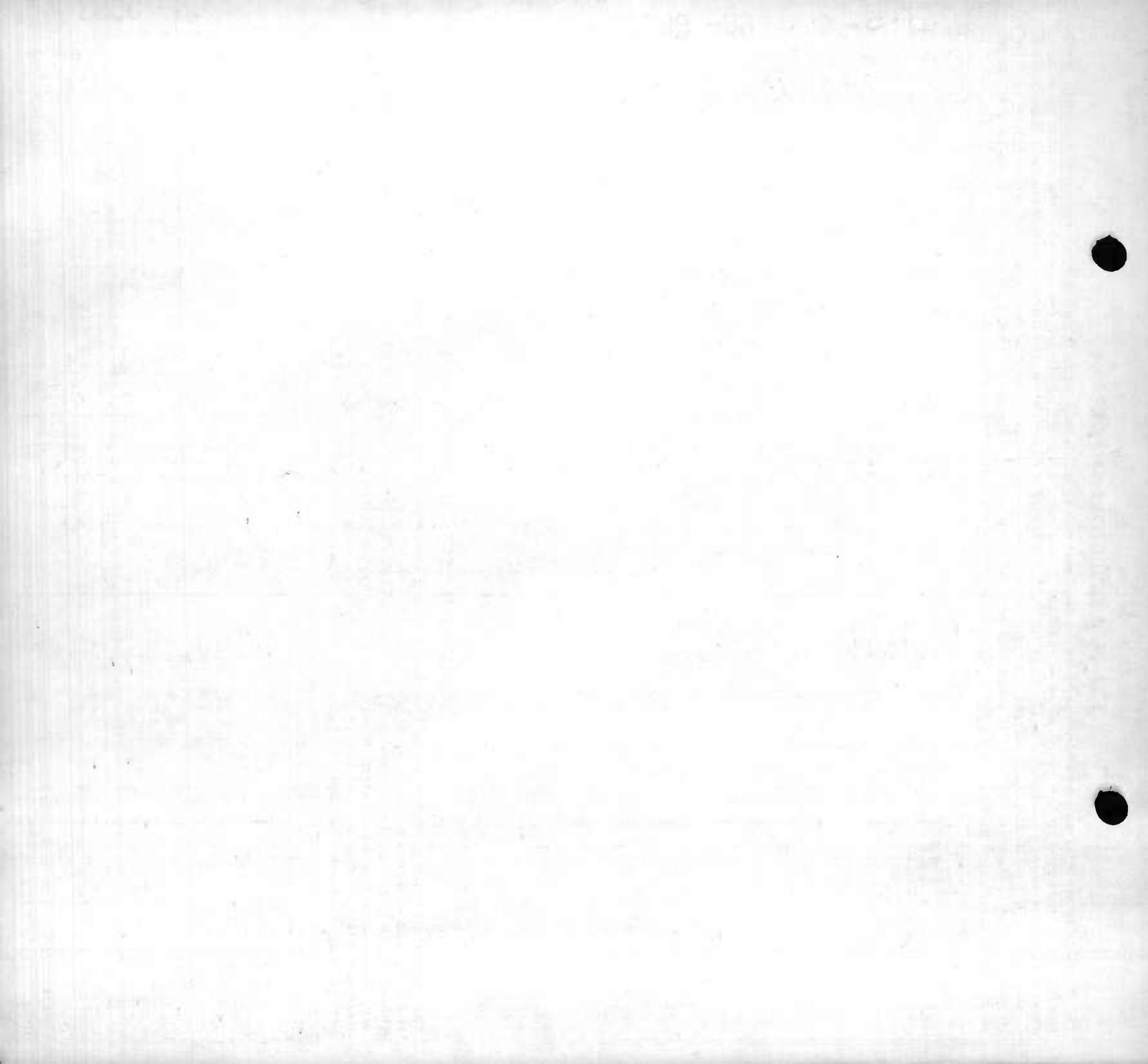
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9092
68- 9092		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELIZABETH J. GLASS		2. DATE AND HOUR OF DEATH 4 Sept 68, 6:55 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSP.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8/11/98		9. AGE (In years last birthday) 71		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE (???)		10B. KIND OF BUSINESS OR INDUSTRY ???????		11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES WALKER		
14. MOTHER'S MAIDEN NAME MARIE KIRBY Louise		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N (DOUBTFUL)		
16. SOCIAL SECURITY NO. D 213 019763		17. INFORMANT Hospital CHART & Friend: Mrs. FLORENCE CORCORAN		
18. 250.9.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC PERIPHERAL VASCULAR DISEASE		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. 430.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		DIABETES, DRY GANGRENE @ FOOT, ASCVD - YEARS		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 21 Aug 1968 to 4 Sept 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 SEPT 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE H. Warren		23B. DATE SIGNED 4 Sept 68		23C. PHYSICIAN'S NAME (Type) H. WARREN
23D. ADDRESS MARYLAND GEN. HOSP.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 9/7/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av., City



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. J-520		BALTIMORE CITY HEALTH DEPARTMENT		68- 9093		68- 9093	
M.E. CASE NO.				Registered No.			
1. NAME OF DECEASED (Type or Print) IDA V. JONES				2. DATE AND HOUR OF DEATH 9-3-68 9:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1025 N. CENTRAL AVE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 10-01			
5. SEX F				6. RACE C.		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 5-12-91		9. AGE (In years last birthday) 77	
13. FATHER'S NAME HENRY ROY				14. MOTHER'S MAIDEN NAME JANE TALIFERTHO			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT IRMA HENRY 1025 N. CENTRAL AVE		ADDRESS	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) Coronary Obstruction DUE TO (B) Arteriosclerosis DUE TO (C) Hypertensive C-V disease		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr 15 yrs 15 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 420.1 II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 1958 to 9-3-1968 , that (I) was last saw the deceased alive on 9-3-1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.							
23A. SIGNATURE R.W. McDaniel				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-6-68	
23C. PHYSICIAN'S NAME (Type) R.W. McDaniel				23D. ADDRESS M.D. 1500 E. Madison St			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/7/68		24C. NAME of CEMETERY or CREMATORY Arbutus M.E. PK		24D. LOCATION (City, town, or county) (State) Arbutus. MD	
25A. DATE RECD BY HEALTH DEPT. SEP 8 1968		25B. NAME OF REGISTRAR Robert E. J...		25C. FUNERAL DIRECTOR Joseph J. Locks Jr		ADDRESS 13040 Central Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 9094		REG. NO. _____	
BIRTH NO. <u>C-420</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>CALLACOWAY MR. DENNY</u>				2. DATE AND HOUR OF DEATH <u>8/19/68 at 12.45 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>CHURCH HOME AND HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>MD.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME AND HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>1.23.10</u>		9. AGE (In years lost birthday) <u>58 yrs</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Lifter</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Stone Lifter</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN(USA)</u>				13. FATHER'S NAME <u>unknown</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>219-18-2350</u>				17. INFORMANT <u>CLAUDINE CALLACOWAY</u>			
18. <u>189.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of left kidney? with metastasis?</u>				19. <u>180X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>unknown</u>			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 5</u> 19 <u>68</u> to <u>Aug 19</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8-19</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>8-19-68</u>		23C. PHYSICIAN'S NAME (Typed) <u>A. E. SUBONG, M.D.</u>	
24A. BURIAL CREATION, REMOVAL (Specify) <u>8/24/68</u>				24B. DATE <u>8/24/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>				25C. FUNERAL DIRECTOR <u>MAURICE A. Callahan</u>			
25D. ADDRESS <u>CHURCH HOME AND HOSPITAL</u>				25E. ADDRESS <u>CHURCH HOME AND HOSPITAL</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9095	
<div style="display: flex; justify-content: space-between;"> <u>D-625</u> 68- 9095 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) DURKIN SUE		2. DATE AND HOUR OF DEATH 8-15-68 7⁵⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSP. 73		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND B. COUNTY BALTO	
		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 808 WILLIAM ST.			
5. SEX F	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-20-1911	9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) WEST. VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN STARR			
14. MOTHER'S MAIDEN NAME PEARL WESTPHAL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT PATIENT		ADDRESS			
18. 57110 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Massive Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Acute Yellow Atrophy Liver DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Lanner's Ankyrosis			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 581.1 II					
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 8-7 19 68 to 8-15-68 19 68 , that (I) <u>(we)</u> last saw the deceased alive on 8-15 19 68 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Donald M. Wood, M.D.		23B. DATE SIGNED 8-15-68		23C. PHYSICIAN'S NAME (Type) DONALD M. WOOD, M.D.	
23D. ADDRESS So. Balto. General Hosp.		24A. BURIAL CREMATION, REMOVAL (Specify) 8/29/68 Health Dept.			
24B. DATE 8/29/68		24C. NAME OF CEMETERY or CREMATORY Health Dept.		24D. LOCATION (City, town, or country) ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert S. [unclear]		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD	

5488

1

68- 9096

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9096

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EUGENE HUGGINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 16, 1968 10:47 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 106 N. Wolfe Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year August 16, 1968 10:47 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		6. SEX Male 7. RACE Negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 54 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 7/24/68 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, MD. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 16, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-29-68	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Ronald N. Kornblum	
25C. FUNERAL DIRECTOR		25D. ADDRESS MORTUARY SERVICE - BCHD	

WALLACE POLICE

VALLEY PARK

2000 ROAD 1000

1
L-500

L-520

68- 9097

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9097

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) ADAM LONG (LOHN)		2. DATE OF DEATH Known <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Hour <input type="checkbox"/> Estimated <input type="checkbox"/> July 17, 1968 6:30 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Hour <input type="checkbox"/> July 17, 1968 6:30 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 54	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fracture of Left Hip (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 601 South Bradford Street		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) July 7, 1968 ? A.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell out of bed while drunk	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) DATE SIGNED July 17, 1968		24. BURIAL CREMATION, REMOVAL (Specify)	
24A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town or county) (State)	
25A. FUNERAL DIRECTOR		25B. ADDRESS	
25C. MORTUARY SERVICE - BCHD			

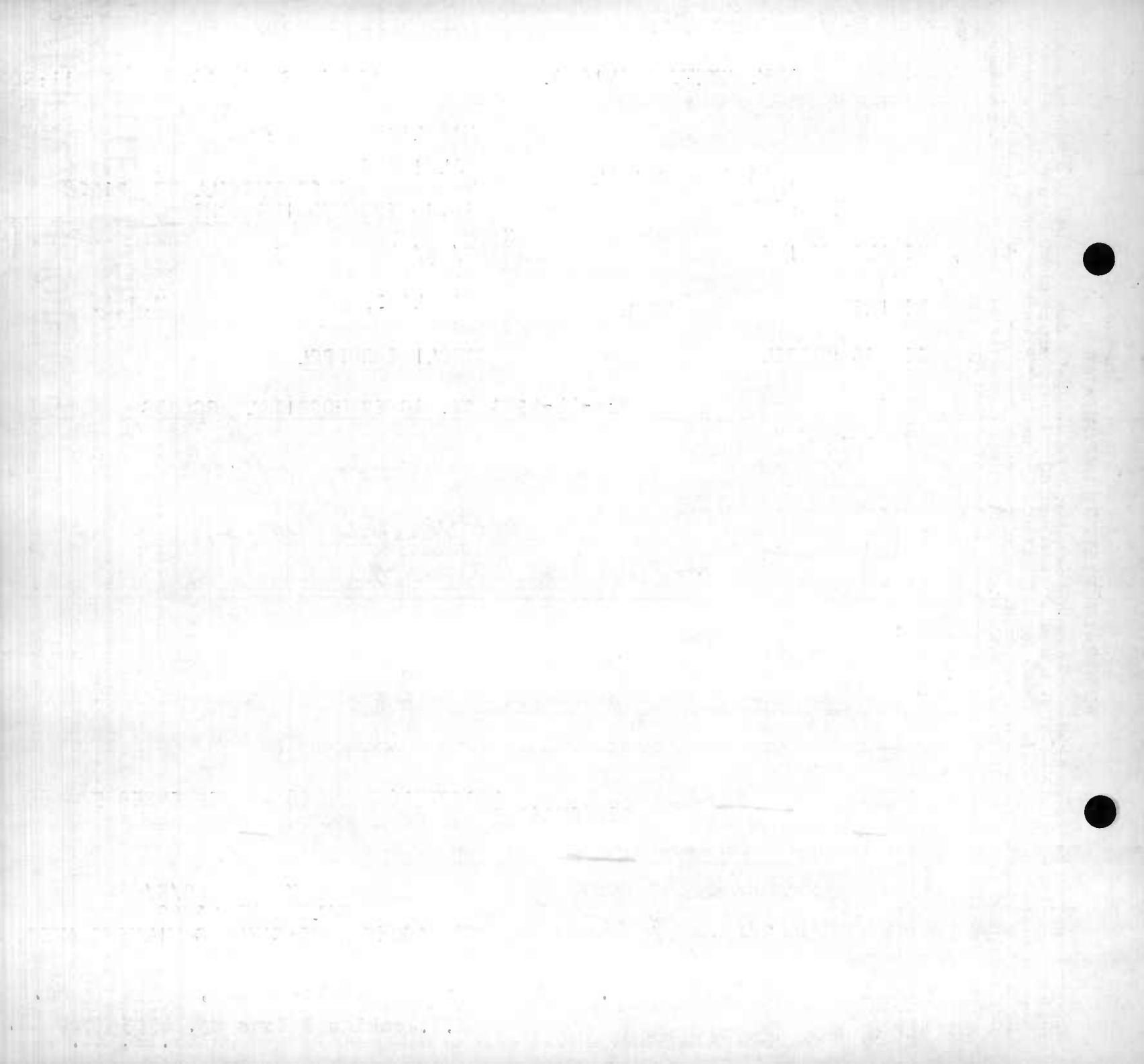
N 820,015 8000 9097

VALLEY REPORT
VALLEY REPORT

FUNERAL DIRECTOR: IMPORTANT

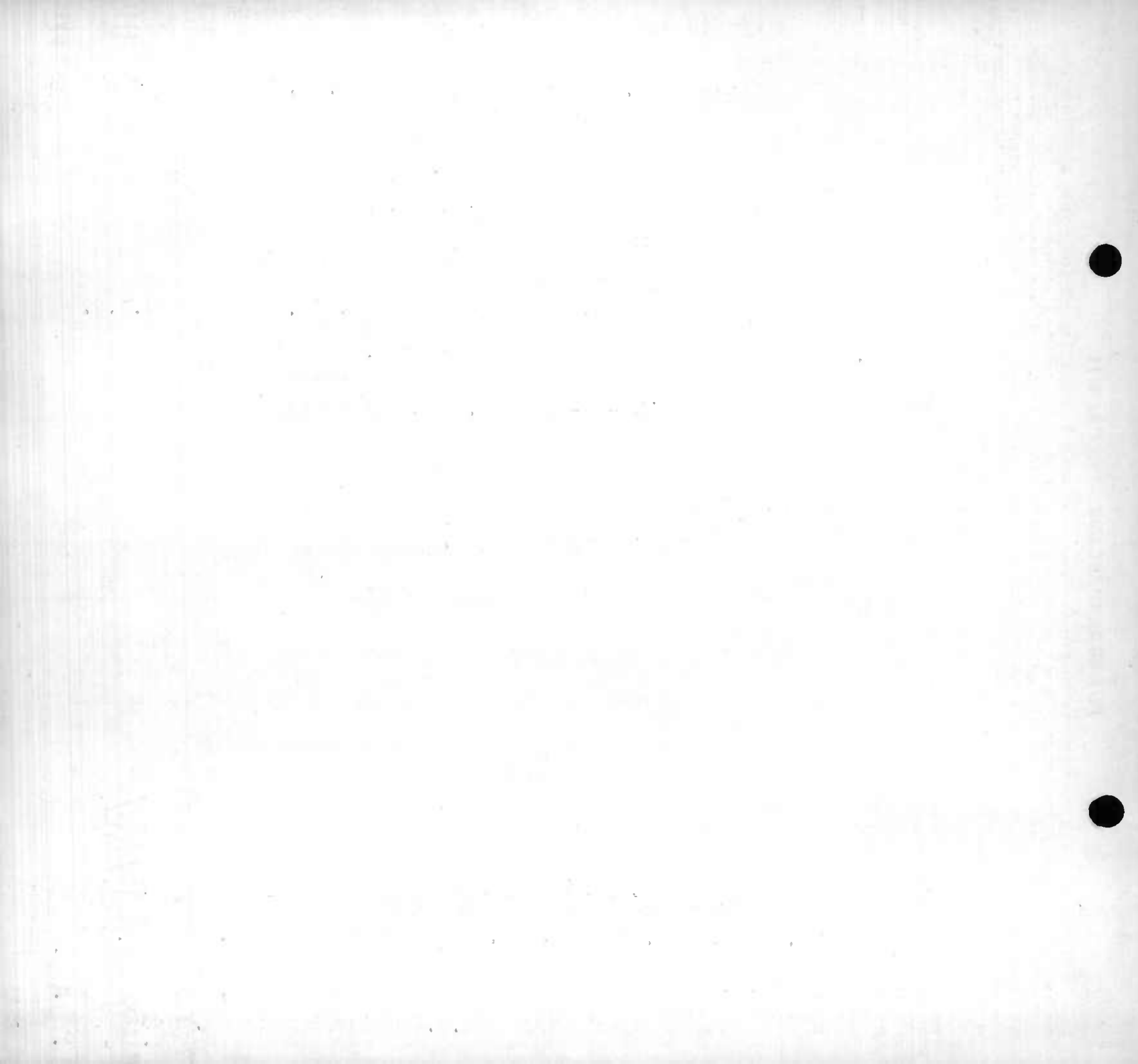
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO.		68- 9098		88- 9098	
1. NAME OF DECEASED (Type or Print)		RUPPEL, XXXX AMALIA G.		2. DATE AND HOUR OF DEATH SEPTEMBER 5, 1968 11:50 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY Balt Co 53-00			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 222 TUGWELL DR 21228 ST. JOSEPH NURSING HOME			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/26/84	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES GEORGE RUPPEL		14. MOTHER'S MAIDEN NAME CAROLINE RUPPEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 220-44-2301		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary infection (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis; atherosclerosis; (C) DUE TO, OR AS A CONSEQUENCE OF: General a. thrombosis			
19. DATE OF OPERATION 0		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 16 19 68 to SEPTEMBER 5 19 68, that (I) (we) last saw the deceased alive on SEPTEMBER 5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anastacia E. Fabie		23B. DATE SIGNED 9/5/68		23C. PHYSICIAN'S NAME (Type) ANASTACIA E. FABIE	
23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.		23E. ATTENDING PHYSICIAN Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/7/1968	24C. NAME OF CEMETERY or CREMATORY St. Paul's Church	24D. LOCATION Violettville, Md.	24E. ADDRESS 4905 York Rd. Balto. 12, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

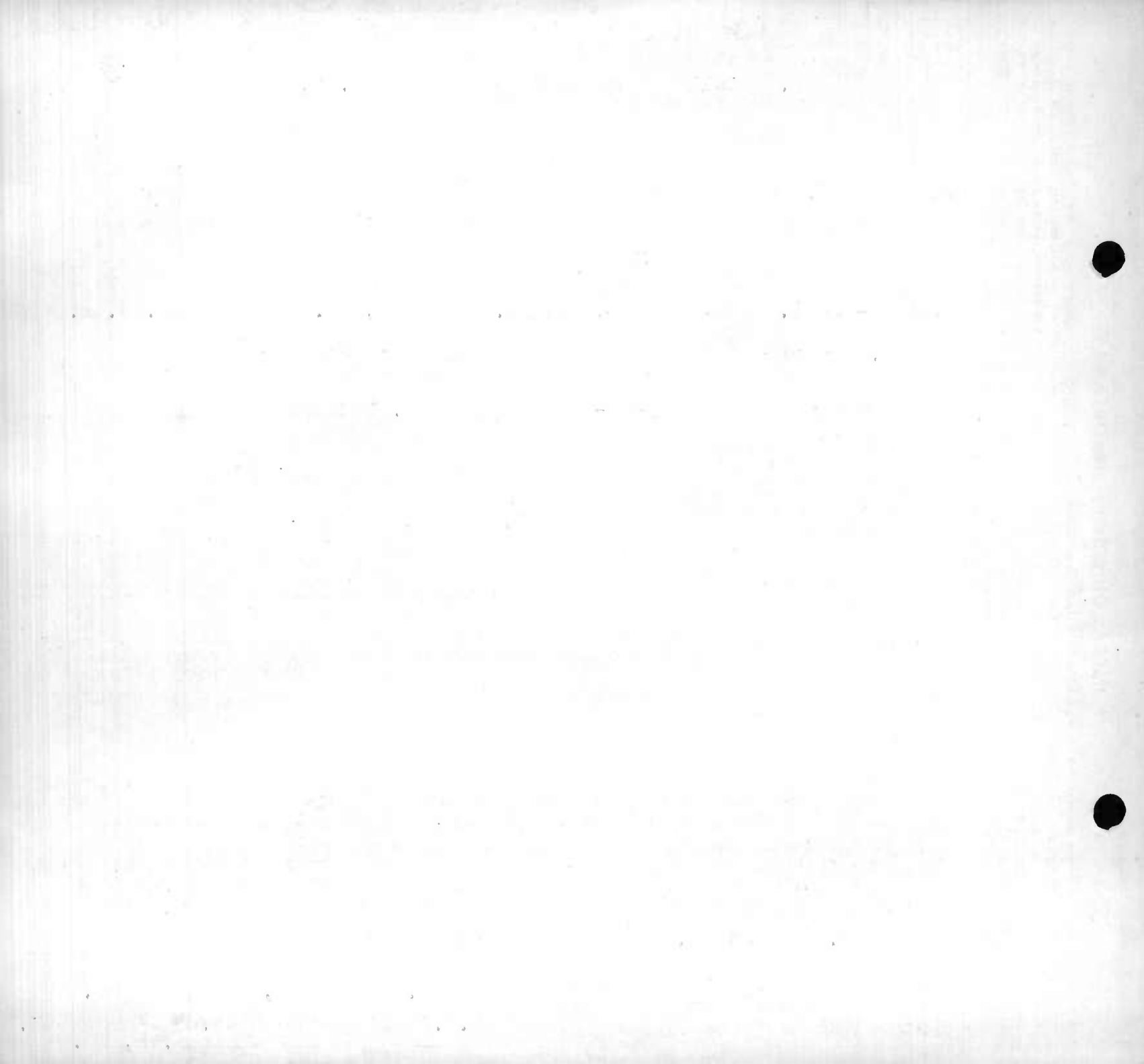
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9099	
BIRTH NO. 6-320 68- 9099				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Elizabeth B. Bates			2. DATE AND HOUR OF DEATH Sept. 5, 1968 8:45 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3601 Greenway			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3601 Greenway		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1896	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Scranton, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John M. Beaumont			14. MOTHER'S MAIDEN NAME Frances A. Brewster		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-22-5314	17. INFORMANT J. Kenneth Bates (Same) ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 154X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 1965 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from December 1965 to September 5, 1968, that (I) (we) last saw the deceased alive on September 4, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE William P. Benson, Jr. M.D. DEGREE 23B. DATE SIGNED Sept. 6, 1968 23C. PHYSICIAN'S NAME (Type) Dr. William P. Benson, Jr. 23D. ADDRESS Carrollton Apts. 3502 N. Calvert St. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/7/1968 24C. NAME of CEMETERY or CREMATORY Greenmount 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968 25B. NAME OF REGISTRAR Robert E. Jenkins 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

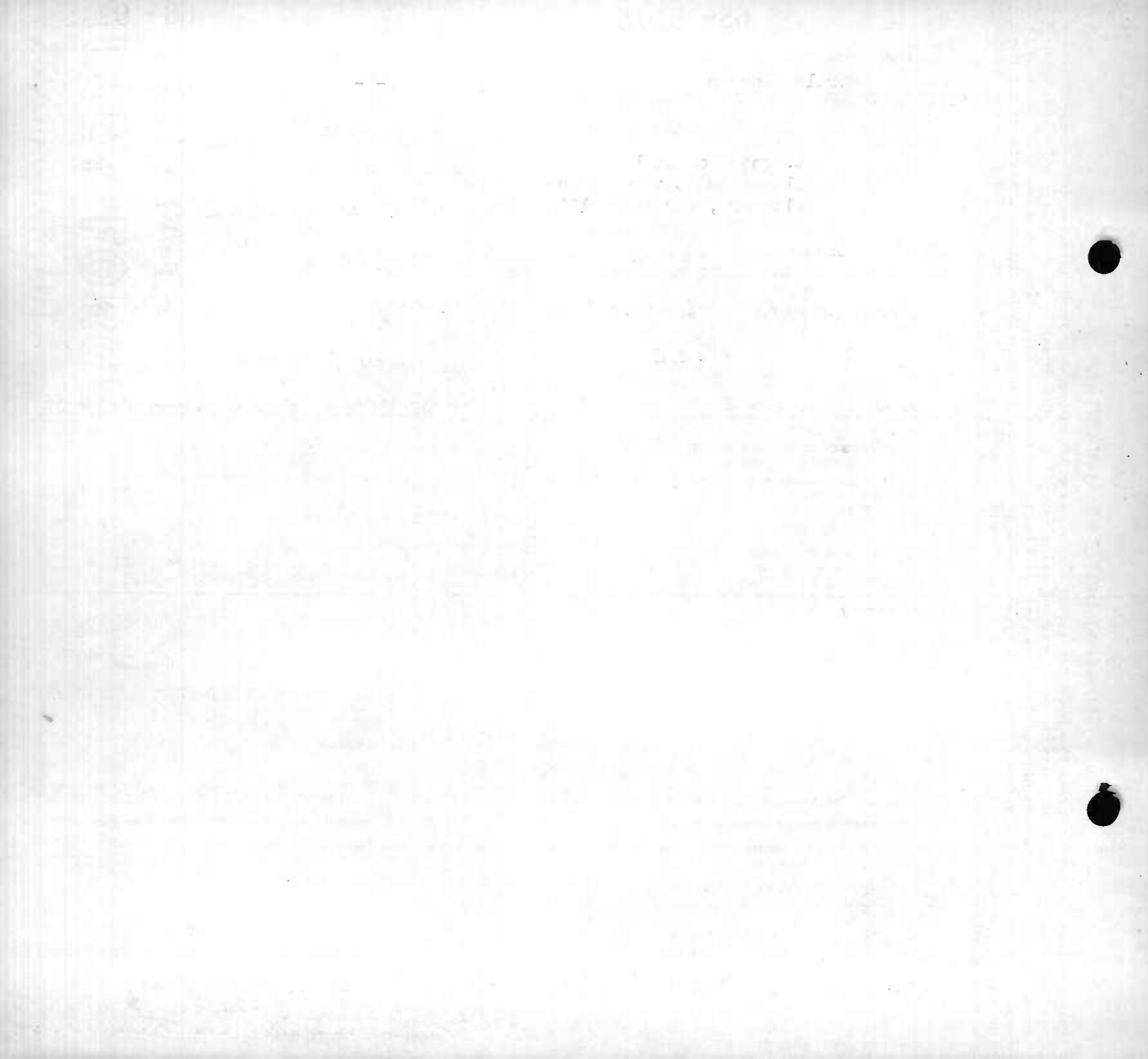
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 9100</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH Sept. 5, 1968 10 1. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		5. SEX M <u>W</u>		6. RACE W
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/26/1890		
9. AGE (In years lost birthday) <u>78</u>		10. CITIZEN OF WHAT COUNTRY? U. S. A.		
11. BIRTHPLACE (State or foreign country) <u>Belair, Md.</u>		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John R. Bedford		14. MOTHER'S MAIDEN NAME Elizabeth Dunnigan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-0701		
17. INFORMANT John R. Bedford		ADDRESS (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma Prostate</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Metastases to Long Bones & Lungs</u> (C)		
19. DATE OF OPERATION 177X II		20. AUTOPSY? (Yes or No) No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>June 10</u> <u>1968</u> to <u>Sept 5</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 5</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date <u>Sept 5</u> <u>1968</u> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Laurence C. Post M.D.</u>		23B. DATE SIGNED <u>9/6/68</u>		
23C. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post		23D. ADDRESS 6805 York Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/7/1968		
24C. NAME OF CEMETERY or CREMATORY BelAir Memorial Grds.		24D. LOCATION (City, town, or county) (State) Belair, Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9101	
<div style="display: flex; justify-content: space-between;"> 68- 9101 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Myrtle Gorman		2. DATE AND HOUR OF DEATH 9-8-68 9:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Wilkens and Catons Avenues Baltimore, Maryland 21229		A. STATE MARYLAND B. COUNTY 22-06 C. CITY OR TOWN BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 505 S. Longwood St.			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1893	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PICE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 1		17. INFORMANT ADDRESS MARY MEILE 503 S. Longwood St.	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antoxic Anoxia -		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Edema - (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure. (C) A.S. C.U.D			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-8-68 19 68 to 9-8- 19 68 , that (I) (we) last saw the deceased alive on 9-8-68 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alejandro Mejia		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA MD.	
23D. ADDRESS St Agnes Hosp. Catons Wilkens Ave.		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23F. DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-11-68		24C. NAME OF CEMETERY or CREMATORY London Park	
24D. LOCATION BALTIMORE MD.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR SEP 9 1968	
24G. FUNERAL DIRECTOR Francis W. Miller 2101 Piedmont Ave.		24H. ADDRESS		24I. DATE	



G-630

68- 9102 BALTIMORE CITY HEALTH DEPARTMENT

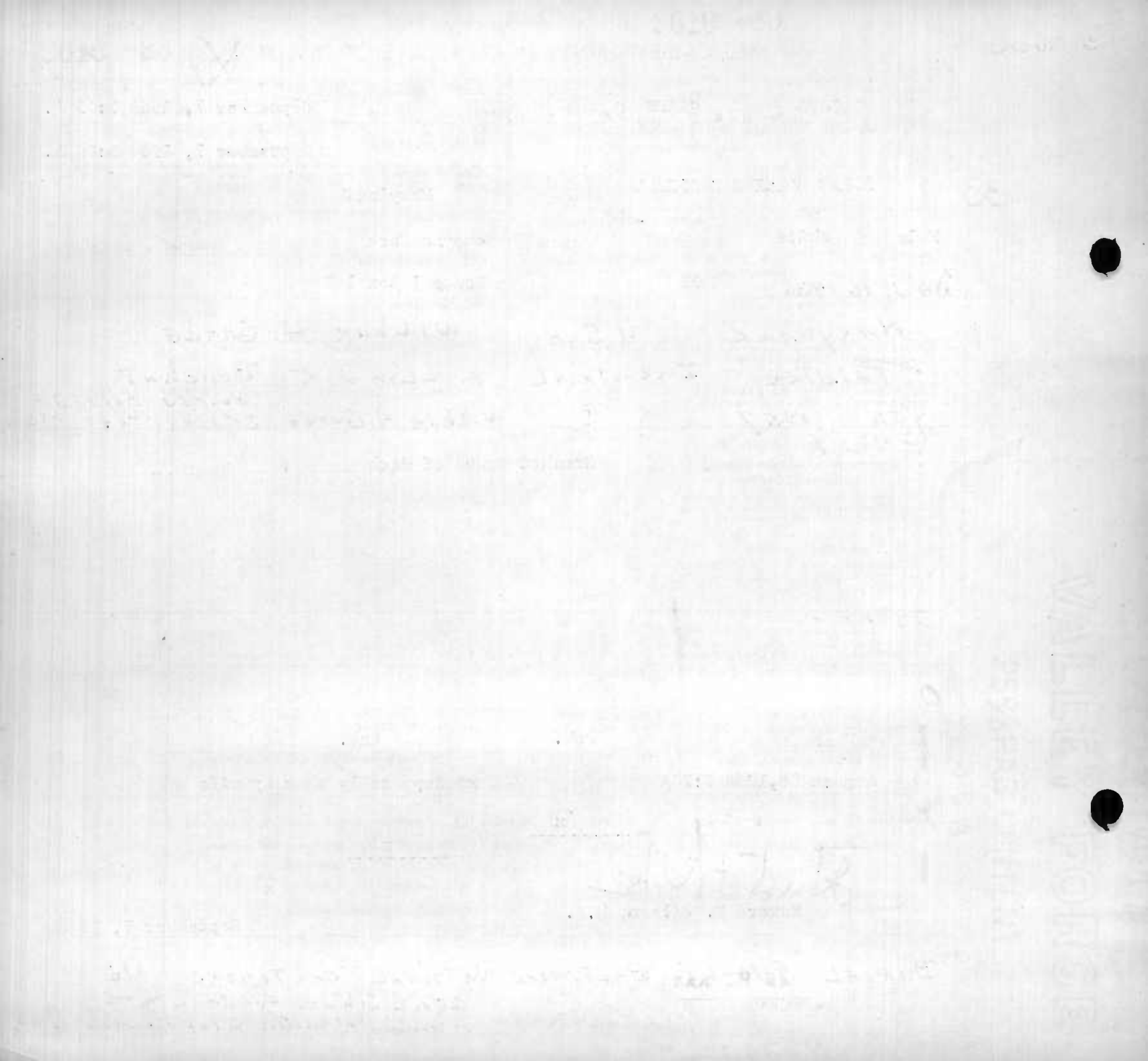
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9102

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROLAND Louis GARDE, Sr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 7, 1968 3:15 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 7, 1968 3:15 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20.0 52-00			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH JAN. 16, 1936		10. AGE (In years lost birthday) 32 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		14B. KIND OF BUSINESS OR INDUSTRY Industrial	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES 1957		17. SOCIAL SECURITY NO. 1	
18. INFORMANT Wilbur H. Garde		ADDRESS Route 1 Box 188A Severna Park Md.	
19. E 965 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 977 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of Neck (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) Unk.	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) August 28, 1968 7:30 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unk.		22F. HOW DID INJURY OCCUR? Supposedly shot by wife	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 7, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-10-68	
24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR GEORGE L. Schwab		ADDRESS Funeral Home 2101 Frederick Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68- 9103	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mabel Moore		2. DATE AND HOUR OF DEATH 9/4/68 7 09 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY 8-06 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1704 N. WOLFE ST.		
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-17	9. AGE (In years lost birthday) 51	II Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10B. KIND OF BUSINESS OR INDUSTRY St. Michael Rectory		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MACK MOORE		14. MOTHER'S MAIDEN NAME HATTIE HORTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 239-12-6669		17. INFORMANT MAGGIE SMITH 1708 N. WOLFE - 21213	
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic failure (B) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF: unknown (C) Carcinoma of breast		
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION Jan. '68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Breast		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Aug. 30 19 68 to Sept. 4 , 19 68 , that (1) last last saw the deceased alive on Sept. 4 , 19 68 and that in (my) four opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David H. Katz, M.D.				23B. DATE SIGNED 9/4/68	
23C. PHYSICIAN'S NAME (Type) DAVID H. KATZ, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-8-68		24C. NAME OF CEMETERY OR CREMATORY PRIVATE	
24D. LOCATION (City, town, or county) (State) RALEIGH N.C.		25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR JOSEPH KNIGHT 1639 N. BROADWAY			

22

THE NEW YORK

LIBRARY OF THE NEW YORK

22

THE NEW YORK

LIBRARY OF THE NEW YORK

THE NEW YORK

LIBRARY OF THE NEW YORK

LIBRARY OF THE NEW YORK

LIBRARY OF THE NEW YORK

LIBRARY OF THE NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9104

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68- 9104

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Barker, Fred

2. DATE AND HOUR OF DEATH

9-7-1968 3:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

36 Franklin Square Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES

NO

E. STREET AND NUMBER

1026 Hollins St.

5. SEX

M

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

7-17-02

9. AGE (In years last birthday)

66

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ervin Barker

14. MOTHER'S MAIDEN NAME

Ester?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

274126590

17. INFORMANT

Harry Barker, Route #6, Westm.

ADDRESS

18. *436.9 I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CVA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

24 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

331X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *Sept. 7 1968* to *Sept. 7 1968*, that (I) (we) last saw the deceased alive on *Sept. 7 1968* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hyung K. Lee, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9/7/68

23C. PHYSICIAN'S NAME (Type)

Hyung K. Lee, M.D.

23D. ADDRESS

100 N. Calhoun St.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

9/10/68

24C. NAME OF CEMETERY or CREMATORY

Mt. Oliver Cem

24D. LOCATION

(City, town, or county)

Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.

SEP 9 1968

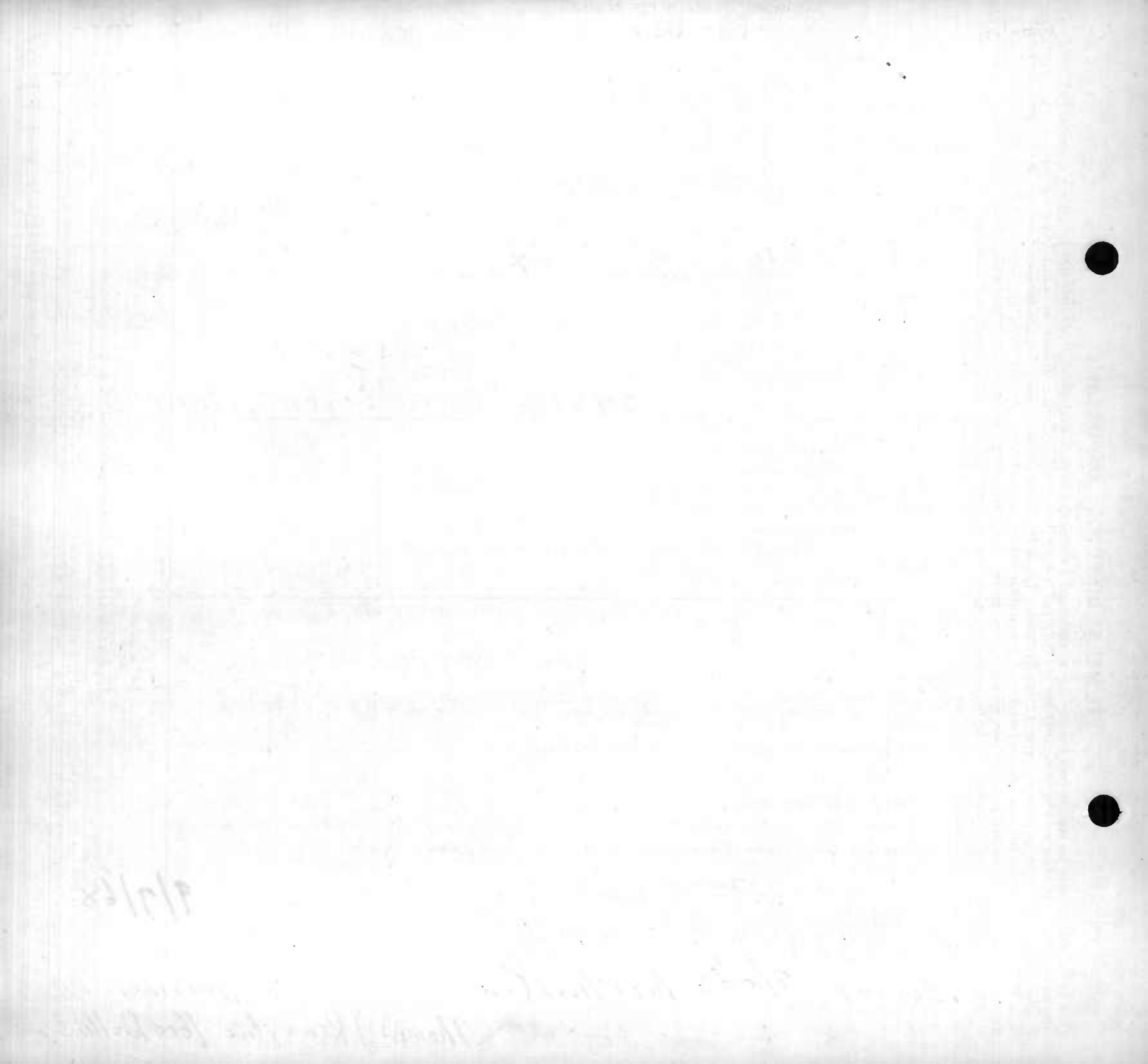
25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Thomas J. Kenney Inc 1600 Dollars &

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

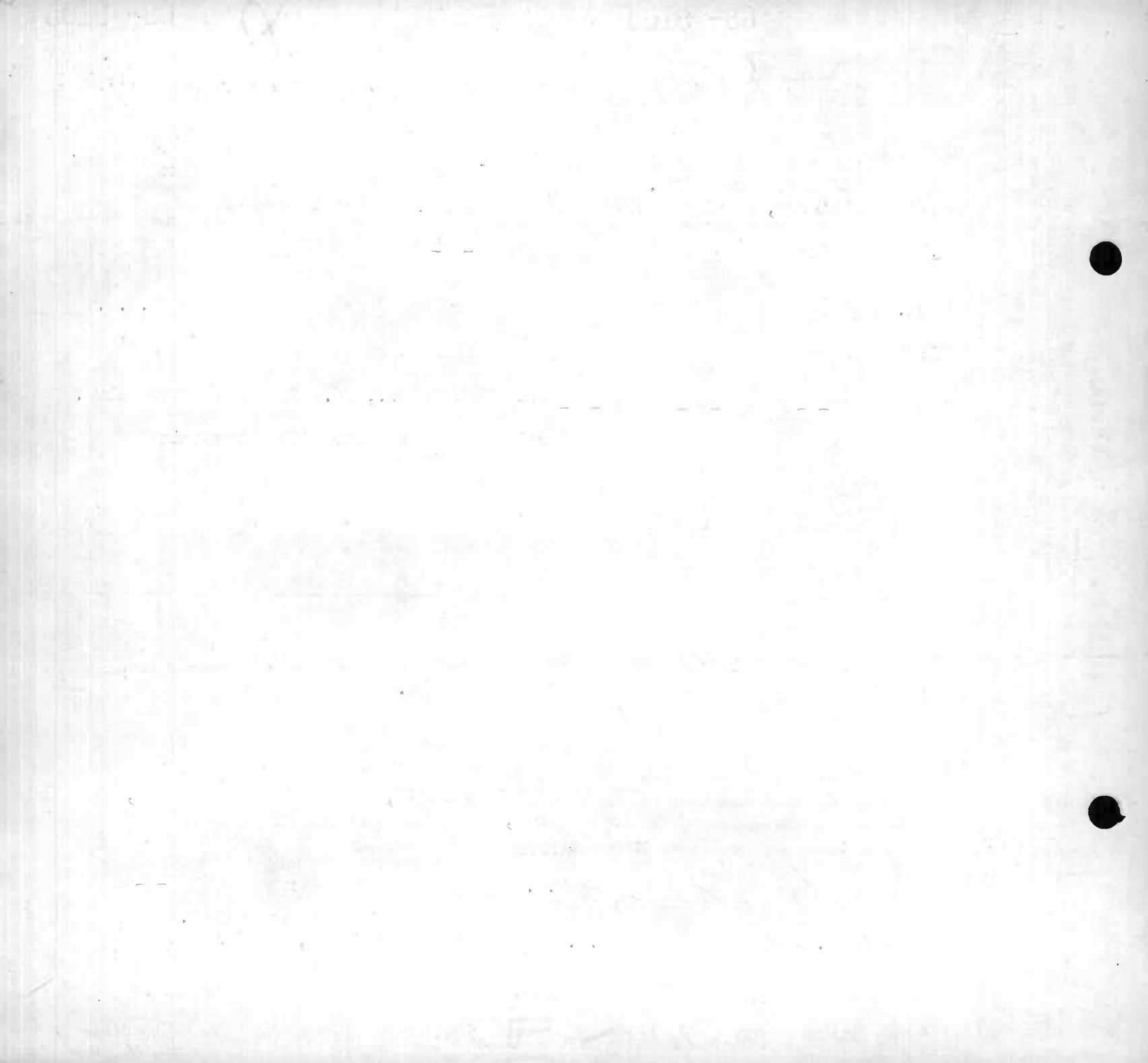
68- 9105

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 9105

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHNSON, Lloyd Edwin		2. DATE AND HOUR OF DEATH September 4, 1968 11:50 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY a.a.c. 52-00		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 2900 Loch Raven Blvd. Baltimore, Maryland 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 23 Ballman Court Ballman	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-22-12	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech. (Auto)		10B. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lloyd Johnson		14. MOTHER'S MAIDEN NAME Nellie Byrd	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12-5-42 to 9-25-43		16. SOCIAL SECURITY NO. 218-07-0970		17. INFORMANT Records ADDRESS VAH, Balto., Md. 3900 Loch Raven Blvd.	
18. I 150X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Esophagus with metastasis to Liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		CAUSE OF DEATH Carcinoma of Esophagus with metastasis to Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19, 1968 to September 4, 1968 , that (X) (we) last saw the deceased alive on September 4, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (not) view the body after death.					
23A. SIGNATURE David N. Marine M.D. DEGREE				23B. DATE SIGNED 9-5-68	
23C. PHYSICIAN'S NAME (Type) David N. Marine M.D. DEGREE				23D. ADDRESS 3900 Loch Raven Blvd. Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/1968		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH/DEPT. SEP 9 1968			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR John J. Conroy & Son, Inc. 901 N. Hollins St. Balto. Md. (21223)			



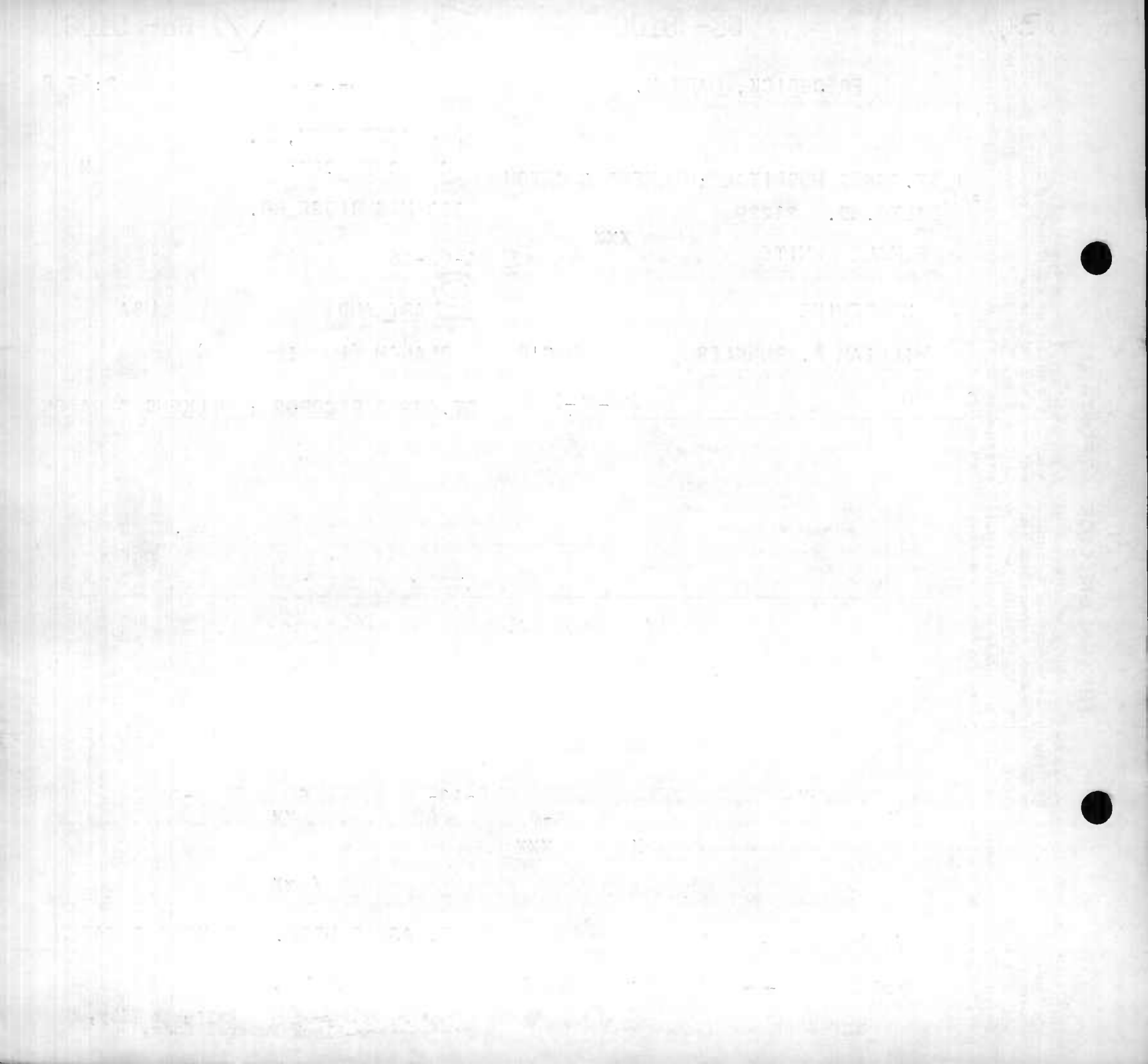
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9106 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9106

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FREDERICK, MARY V.		2. DATE AND HOUR OF DEATH 9-2-68 2:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Harward Co 63-00		C. CITY OR TOWN ELLCOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL ; WILKENS & CATON BALTO. MD. 21229		E. STREET AND NUMBER 323 HIGHRIDGE RD.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-28-26	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM F. RUNKLES DEC'D		14. MOTHER'S MAIDEN NAME BLANCH (Staublicz)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-22-6408		17. INFORMANT ADDRESS ST. AGNES RECORDS ; WILKENS & CATON	
18. I 3-81.0 II		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Long - Heart failure -		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Water + Electrolyte Imbalance			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 1 + hypoproteinemia		(B) DUE TO, OR AS A CONSEQUENCE OF: Nutritional Encephalosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (IX) (this hospital) attended the deceased from 8-13- 19 68 to 9-2 19 68 , that (X) (we) last saw the deceased alive on 9-2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alejandro Mejia</i> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-02-68	
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA MD DEGREE		23D. ADDRESS V ST. AGNES HSOP. WILKENS & CATON			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-5-1968	24C. NAME OF CEMETERY or CREMATORY Morgan Chapel		24D. LOCATION (City, town, or county) (State) Woodbine, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>John M. Slack</i> Highbotham-Slack Funeral Home, Ellicott City, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9107 CERTIFICATE OF DEATH

REG. NO.

68- 9107

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CULLISON WILLIAM S. V.

2. DATE AND HOUR OF DEATH

SEPT. 4, 1968

2:08 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

49 NORTH CHARLES GEN. HOSPITAL
NORTH CHARLES ST.
BALTIMORE MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND BALTIMORE G 53-00

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

7117 WILLOWDALE AVE. 21206

5. SEX

M

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2/8/23

9. AGE (In years last birthday)

45 yrs

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MOTOR REPAIRMAN

10B. KIND OF BUSINESS OR INDUSTRY

Lange Electric Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

UNITED STATES

13. FATHER'S NAME

VONDA CULLISON

14. MOTHER'S MAIDEN NAME

MARGARET JERSCHIED

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL SECURITY NO.

219-12-93-20

17. INFORMANT

Mrs Jean L. Cullison 7117 Willowdale A

ADDRESS 21206

18. 348.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Myotrophic lateral sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

356.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (if this hospital) attended the deceased from AUG. 8, 1968 to SEPT. 4, 1968, that (I) (we) last saw the deceased alive on SEPT. 4, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEOGRACIAS V. FAUSTINO M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9/4/68

23C. PHYSICIAN'S NAME (Type)

DEOGRACIAS V. FAUSTINO M.D.

23D. ADDRESS

NORTH CHARLES GEN. HOSP. BALTO., MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-7-1968

24C. NAME OF CEMETERY OR CREMATORY

Gardens of Faith Cemetery

24D. LOCATION

Baltimore Co.

(City, town, or county)

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 9 1968

25B. NAME OF REGISTRAR

Robert E. Tarkenton

25C. FUNERAL DIRECTOR

Passahut Home 7401 Belair Rd

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9108

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9108

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM WOOD		2. DATE AND HOUR OF DEATH SEPT. 3, 1968 11:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3806 FLEETWOOD AVENUE 21266	
5. SEX M	6. RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 26, 1882	9. AGE (In years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balti. Trans. Retired		10B. KIND OF BUSINESS OR INDUSTRY Balti. Transit Company		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Samuel Wood		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 115-09-3659A		17. INFORMANT Elsie M. Wood ADDRESS 3806 Fleetwood Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 434.2 II Cardiogenic Shock		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Pulmonary Edema		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary Edema		3 1/2 hrs	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Acute Anterior Septal MI.			
		(C) Diabetes Mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 3, 1968 to Sept 3, 1968 , that (I) (was) lost saw the deceased alive on Sept. 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Hong Ti Chau MD.				23B. DATE SIGNED 9-3-68	
23C. PHYSICIAN'S NAME (Type) HONG TI CHAU, MD				23D. ADDRESS THE UNION MEMORIAL HOSPITAL Union Mem. Hosp. Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/68		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) MD.		24E. NAME OF REGISTRAR Robert E. Jenkins		24F. FUNERAL DIRECTOR Lashun F. Jones	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

183

THE

Franklin D. Roosevelt

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

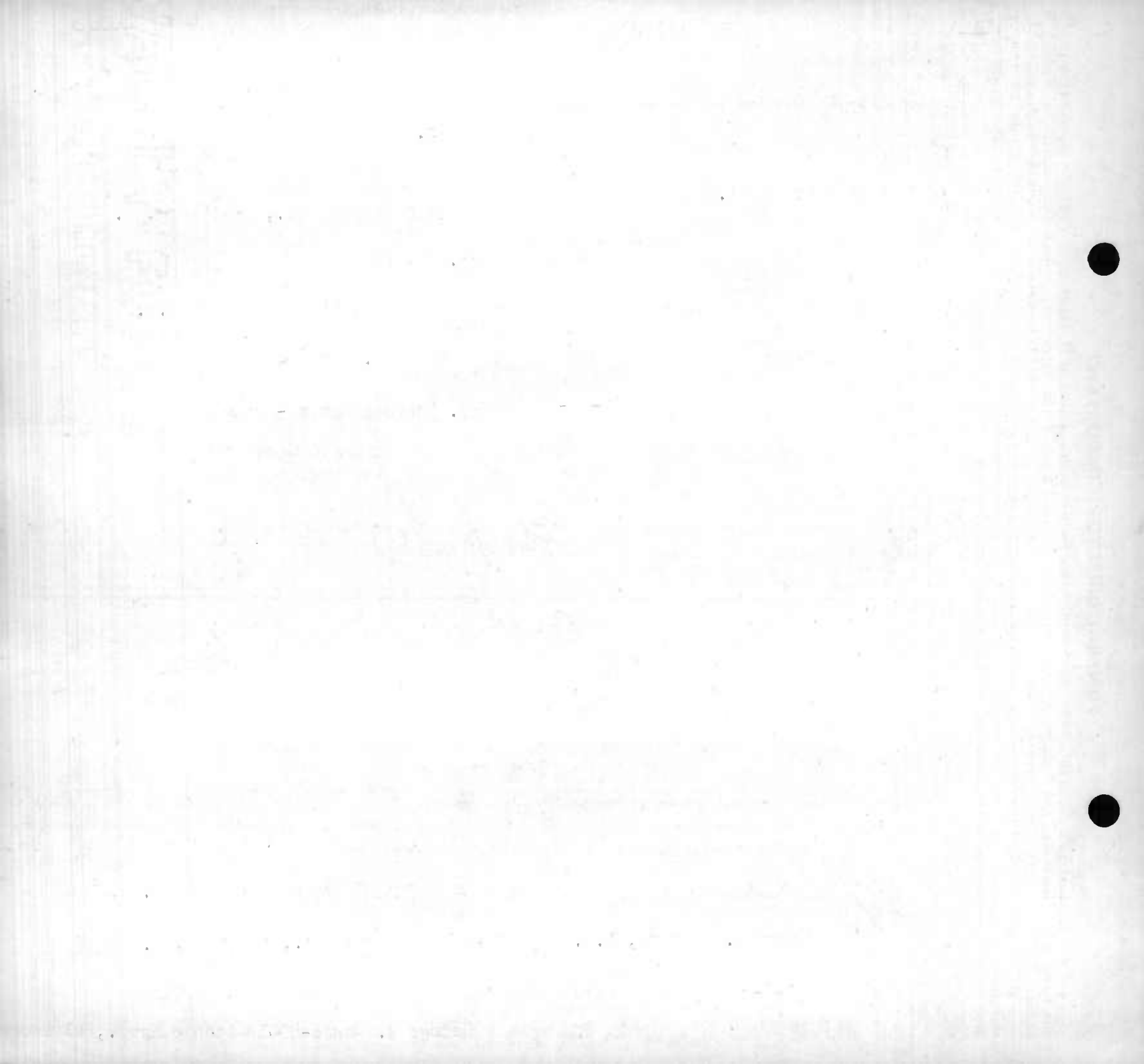
68- 9109 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9109

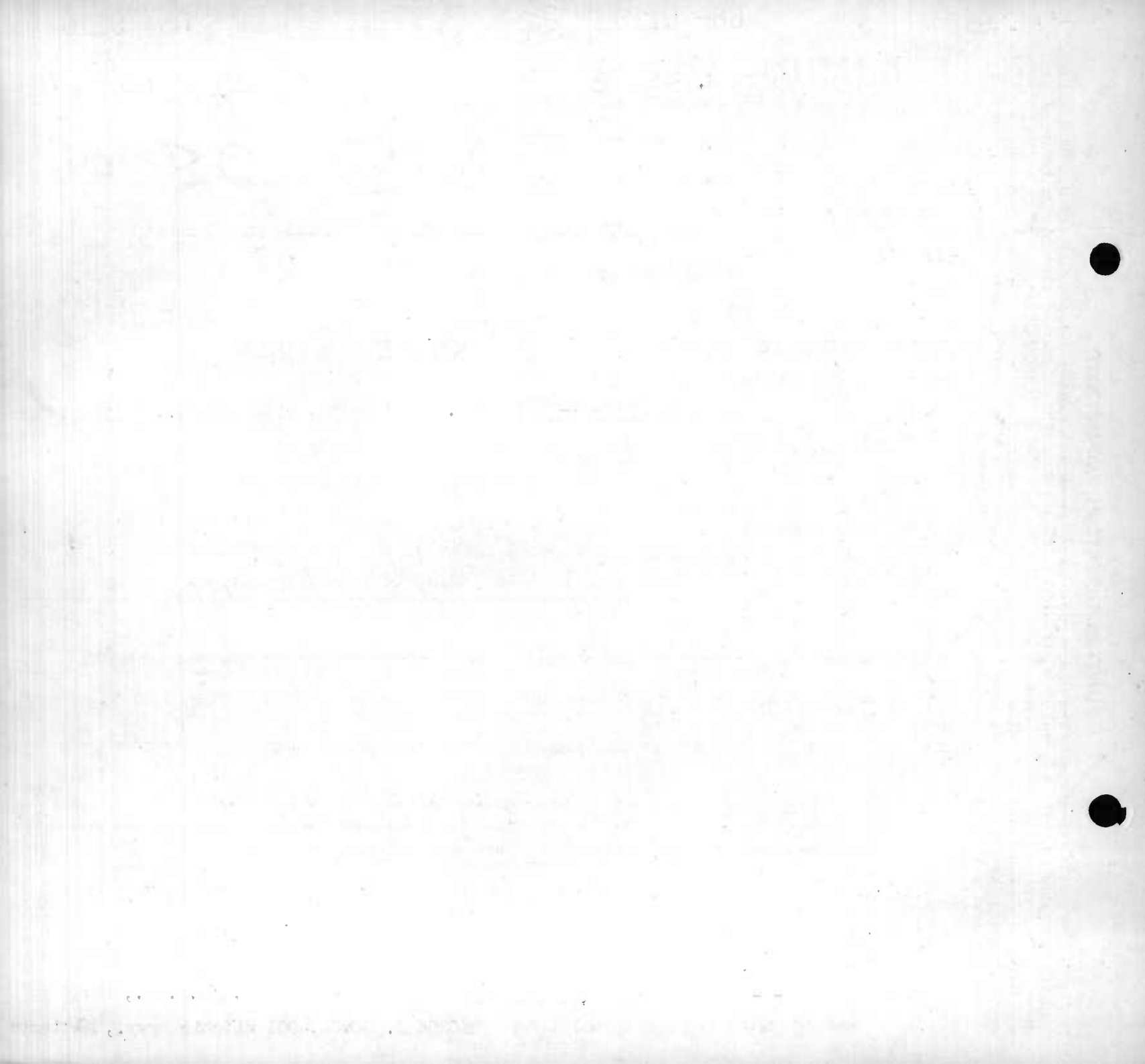
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JAMES CARROLL LENTZ		September 2, 1968 3:00A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 1212 Carroll St.				A. STATE Md. C. CITY OR TOWN Baltimore E. STREET AND NUMBER 1212 Carroll St., Baltimore, Md. 21230	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY Construction		8. DATE OF BIRTH Oct. 31, 1902	
13. FATHER'S NAME Edward Lentz		14. MOTHER'S MAIDEN NAME Katie B. Stevens		9. AGE (In years last birthday) 65	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-5258		12. CITIZEN OF WHAT COUNTRY? U.S.	
		17. INFORMANT Mrs. Theresa Lentz - same		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Generalized Carcinoma of the Lung</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cx of Lung</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Cerebral metastases</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9</i> <i>7 yrs</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1960</i> to <i>Aug 29 1968</i> , that (I) (we) last saw the deceased alive on <i>8-29 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Henry G. Summers</i> NAME (Type) Henry G. Summers, M.D.				23B. DATE SIGNED Sept. 3, 1968	
23C. PHYSICIAN'S NAME (Type) Henry G. Summers, M.D.				23D. ADDRESS 1101 Patapsco Ave., Baltimore, Md. 21225	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-5-1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 9 1968		24F. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
24G. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		24H. ADDRESS		24I. DATE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

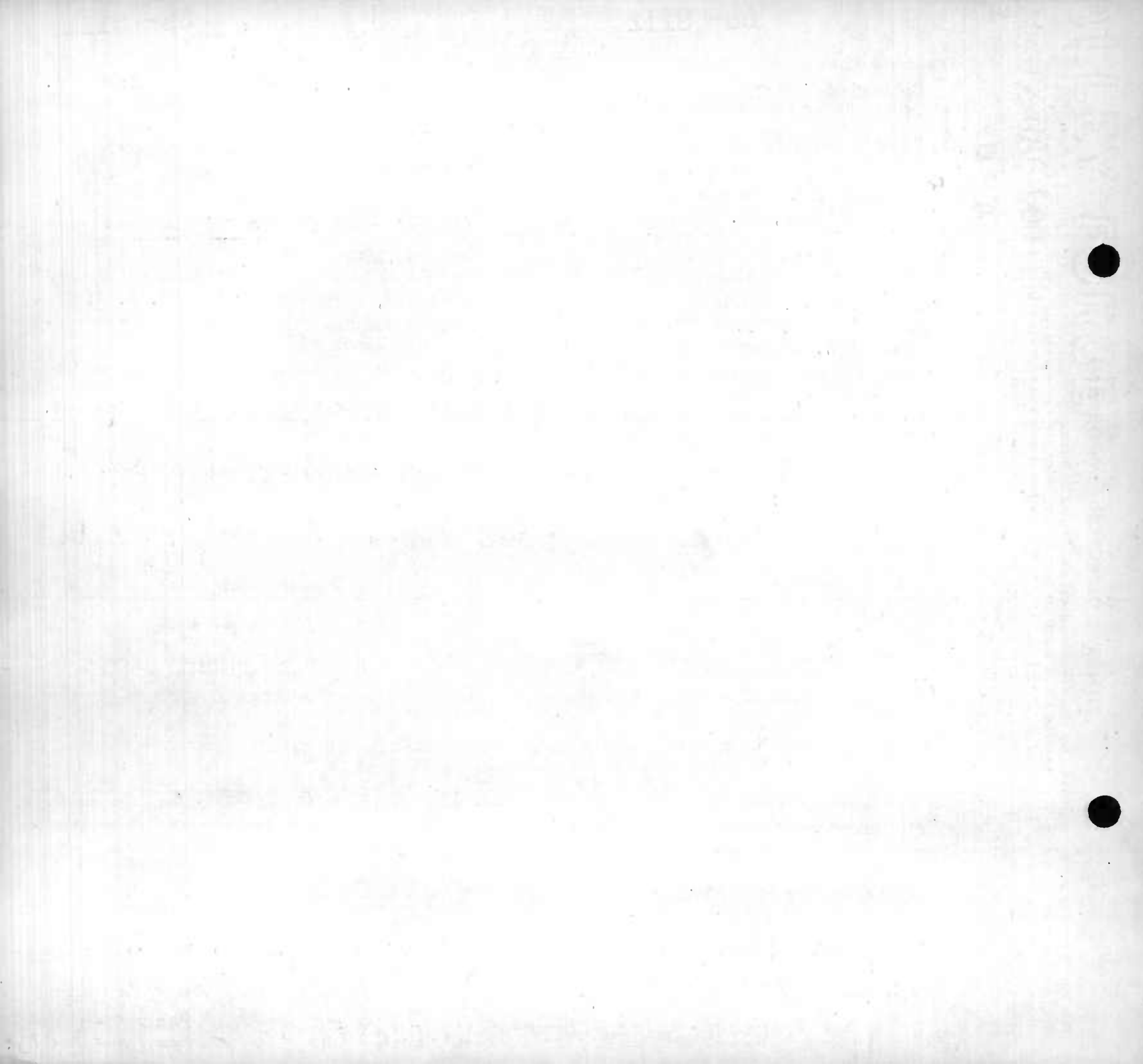
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9110
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HOWARD S. SELIG		2. DATE AND HOUR OF DEATH Sept. 3, 1968 10⁴⁰ A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3802 LEO ST.		
5. SEX Male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-09	9. AGE (In years lost birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JOHN SELIG		14. MOTHER'S MAIDEN NAME KATIE SIPES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-07-3167		17. INFORMANT Mrs. Ethel Selig, 3802 Leo St., Baltimore
18. 537.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Possibly MALNUTRITION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dumping Syndrome (B) DUE TO, OR AS A CONSEQUENCE OF: probably (C) gastrectomy for Abdom. symp.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mo.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 545X II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 27, 1968 to Sept. 3, 1968 , that (I) (we) lost saw the deceased alive on SEPT. 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Albert Lee Daw M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 3, 1968
23C. PHYSICIAN'S NAME (Type) ALBERT LEE DAW M.D.		23D. ADDRESS SOUTH BALTIMORE GEN. HOSP.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-6-1968	24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hwy., A.A.Co., Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR ADDRESS GEORGE J. GONCE, 4001 Ritchie Hwy., Baltimore



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9111	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Catherine Touhey				Sept. 5, 1968 1:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 91 Jenkins Memorial Hospital 1000 Caton Avenue Baltimore, Md. 21229				A. STATE Md. B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2700 N. Charles St.	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1892	9. AGE (in years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fur Buyer-Dept. Store			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Dennis K. Touhey			14. MOTHER'S MAIDEN NAME Kate Lynch		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 213-09-4619A		17. INFORMANT Jenkins Memorial Hospital 1000 Caton Ave.
18. 4-57.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident 2-4 hrs (B) Cerebral Arteriosclerosis 1 yr (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 15 19 68 to Sept. 5 19 68 , that (I) (we) last saw the deceased alive on Sept. 5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel del Rodriguez				23B. DATE SIGNED 9-5-68	
23C. PHYSICIAN'S NAME (Type) Manuel del Rodriguez				23D. ADDRESS Jenkins Memorial Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-7-68		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR WALTERS FUNZ HOME	
				ADDRESS PRATT & STRICKER STS.	



1
5-120

68- 9112 BALTIMORE CITY HEALTH DEPARTMENT

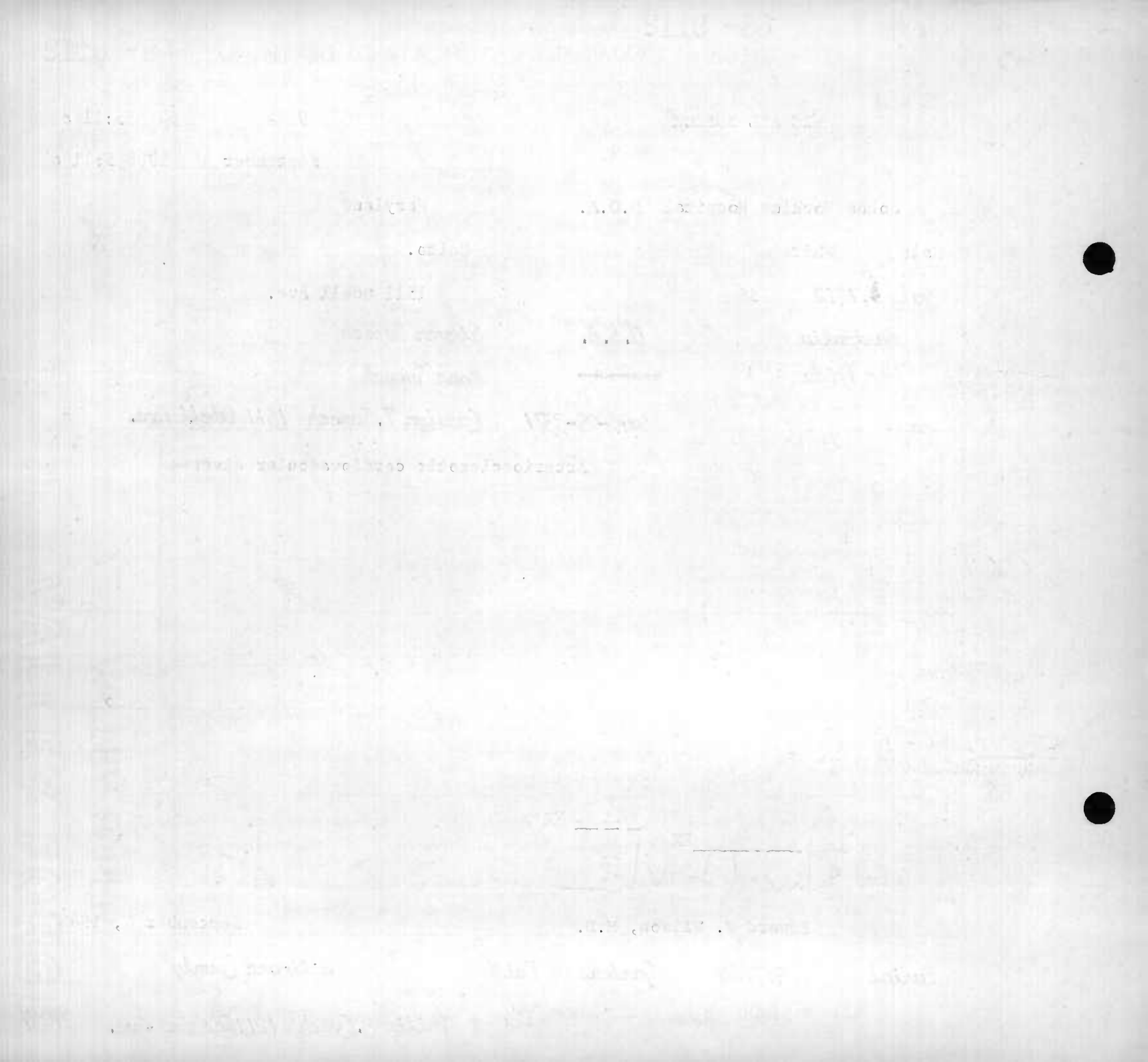
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9112

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MICHAEL SUPECK		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 4 68 5:11 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour September 4 1968 5:11 a. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH July 4 1912		10. AGE (In years lost birthday) 56	
11. BIRTHPLACE (State or foreign country) Australia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender		14B. KIND OF BUSINESS OR INDUSTRY -----	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 096-09-371	
18. INFORMANT Carolyn T. Supeck		ADDRESS 1511 Odell Ave.	
19. CAUSE OF DEATH 412.4 I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 4 22 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S SIGNATURE Edward F. Wilson		M.D.	
NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/7/68	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore County	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Tankersley	
25C. FUNERAL DIRECTOR Philip E. Cvach		ADDRESS 1211 Chesaco Ave. 21237	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9113 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9113
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CLARENCE S. REID		2. DATE AND HOUR OF DEATH SEPTEMBER 4 1968 11:15 AM.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3215 RYERSON CIRCLE		
5. SEX M	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/59	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN		10B. KIND OF BUSINESS OR INDUSTRY BOILER WORKS		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN REID		
14. MOTHER'S MAIDEN NAME LUELLA HADAMIR MUIR		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		
16. SOCIAL SECURITY NO. 218-12-2992		17. INFORMANT ADDRESS Jerome A. Downs - 3215 Ryerson Circle		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR YEARS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		PNEUMOTHORAX MINUTES		
19A. DATE OF OPERATION 9/4/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HYPERTENSIA		20A. AUTOPSY? (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) MEDICAL EXAMINER NOTIFIED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 9/2 19 68 to 9/4 19 68 , that (I) (we) last saw the deceased alive on 9/4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Charles M. Harrison MD		23B. DATE SIGNED 9/4/68		23C. PHYSICIAN'S NAME (Type) CHARLES M. HARRISON MD
23D. ADDRESS UNIVERSITY HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 9-6-1968		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce-4001 Ritchie Hwy., Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9114 CERTIFICATE OF DEATH

REG. NO. **68- 9114**

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Harry Kirk Edmeades		9-4-1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
90 Gould Nursing Home				Md. <i>Harford Co. 62-00</i>	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				Box 434 Rt#1 Fallston, Md. 21047	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Cau.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-9-1890	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Guard		Edgewood Arsenal		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William T. Edmeades			Laura Staylor		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes W.W.1		216-07-7761		M. Magdalena Edmeades Fallston, Md. 21047	
18. <i>433.9 I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				<i>3 mo.</i>	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				<i>Cerebral Thrombosis</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) <i>Arteriosclerosis</i>	
				(C) _____	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
332X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>9-3-1968</i> to <i>9-4-1968</i> , that (I) (we) last saw the deceased alive on <i>9-3-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Wyman K. Wong, M.D.</i>				<i>9-5-68</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Wyman K. Wong, M.D.				6801 Belair Road Baltimore, Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-7-1968		Parkwood Cemetery	
				Baltimore, Co. Md	
25A. DATE RECEIVED BY HEALTH DEPARTMENT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 8 1968		<i>Charles E. Sallaha</i>		Lassahn Funeral Home 7401 Belair Road	

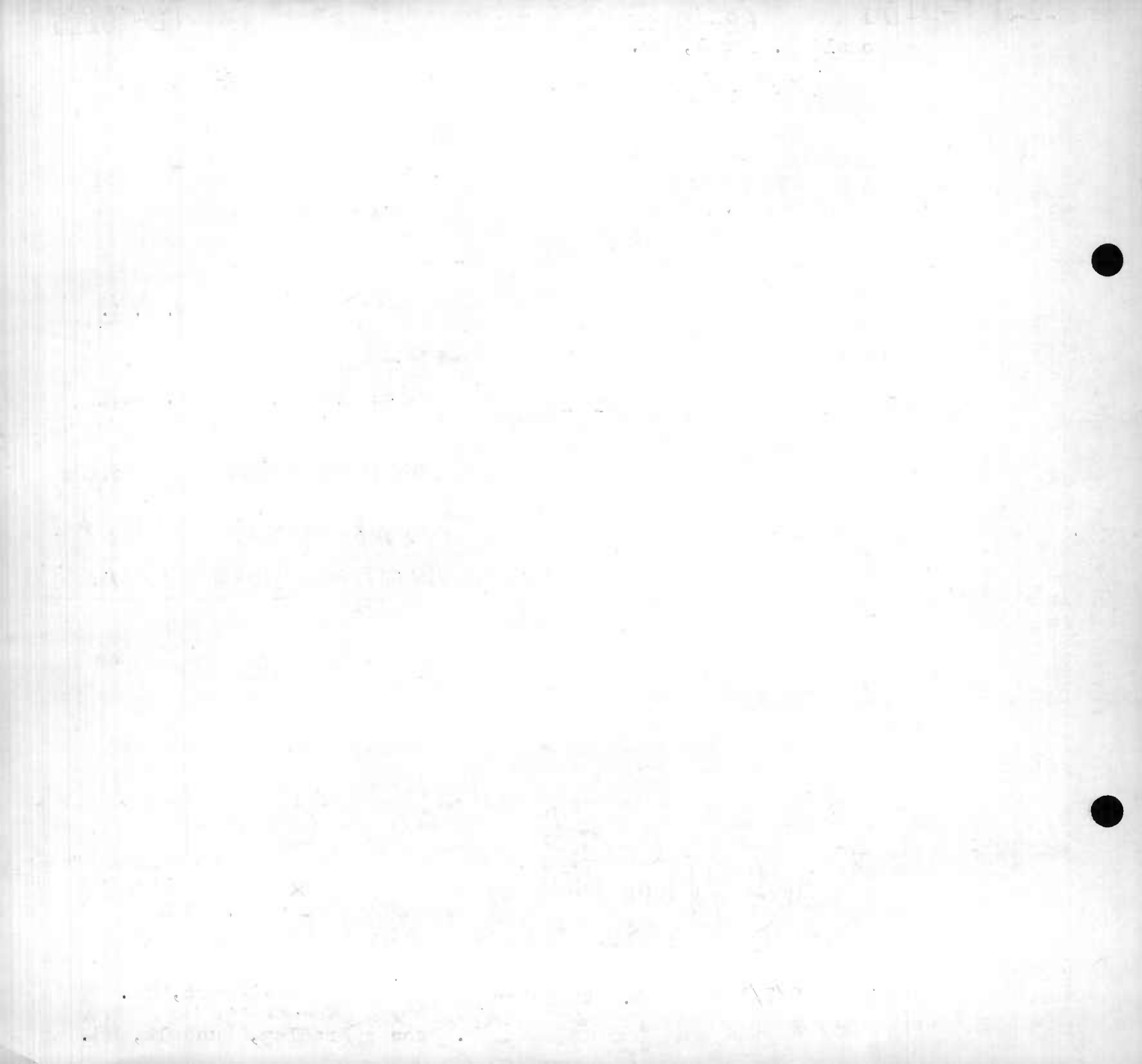
CERTIFICATE OF DEATH

REG. NO.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

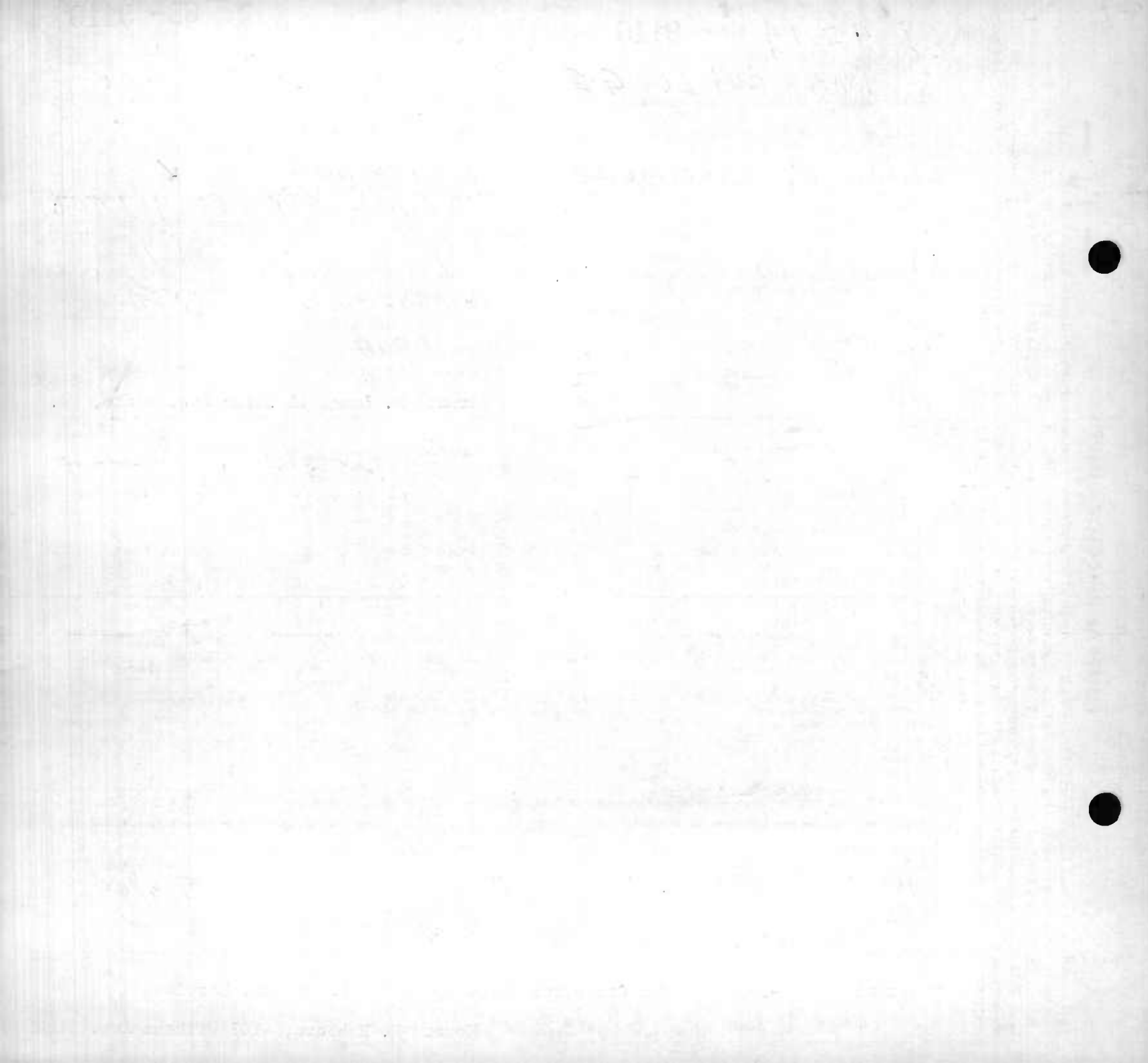
BIRTH NO. Donald E. Pfeil, Sr.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9115	
1. NAME OF DECEASED (Type or Print) Donald E. Pfeil		2. DATE AND HOUR OF DEATH September 4, 1968 12 45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? 26 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5910 PLUMMER AVENUE 21206					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-30	9. AGE (In years lost birthday) 38	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME FREDERICK		14. MOTHER'S MAIDEN NAME IRENE HEINEA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-26-2060		17. INFORMANT BCH RECORDS: 4940 EASTERN AVE. 21224	
18. 206.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Thrombocytopenia DUE TO, OR AS A CONSEQUENCE OF: (C) Acute Monoblastic leukemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 1 wk. 2 mos.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 204.2 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12/1968 to 9/4/1968 , that (I) (we) last saw the deceased alive on 9/4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Shaw, MD		23B. DATE SIGNED 9/4/68		23C. PHYSICIAN'S NAME (Type) DAVID J. SHAW, M.D.	
23D. ADDRESS 4940 EASTERN AVE. 21224		23E. FUNERAL DIRECTOR'S NAME (Type) W. Brooks Bradley			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/7/1968		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968			
25B. NAME OF REGISTRAR Paul E. Jackson		25C. ADDRESS W. Brooks Bradley, Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9116 4
BIRTH NO. 42619		68- 9116 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY BOY LONG		2. DATE AND HOUR OF DEATH 9/2/68 8¹⁰ PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD 8. COUNTY BALTIMORE CO		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI OF BALTIMORE		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 12 BLANK AVE FT. HOWARD				
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/68	9. AGE (In years last birthday) 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME BERNARD		14. MOTHER'S MAIDEN NAME GLORIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Bernard A. Long, 12 Blank Ave. Blato, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 776X II				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from 9/2 1968 to 9/3 1968 , that (1) (we) lost saw the deceased alive on 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Judith F. Strauss MD		23B. DATE SIGNED 8/3/68		
23C. PHYSICIAN'S NAME (Type) JUDITH STRAUSS MD		23D. ADDRESS Inner of Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-5-68	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

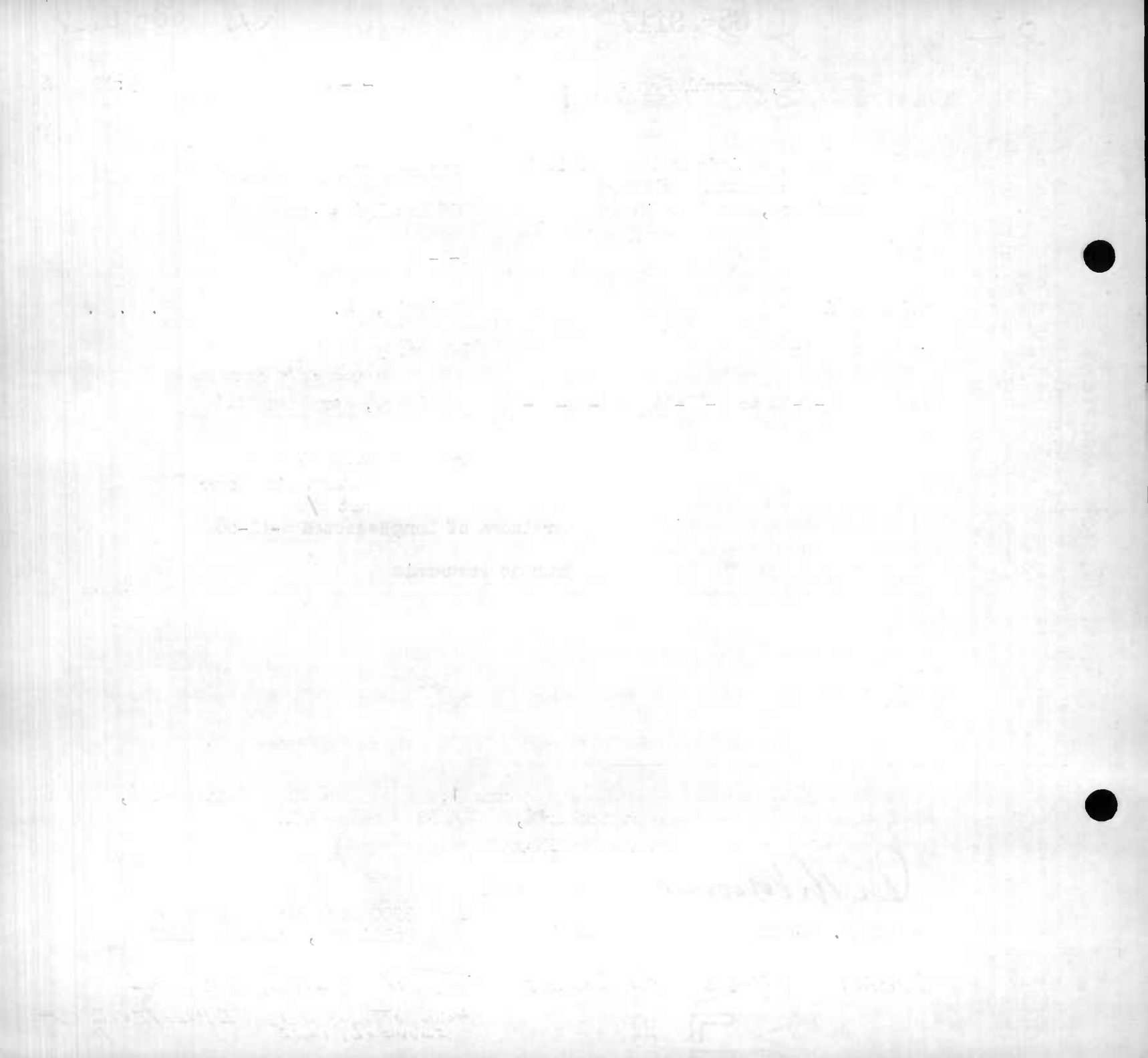
68- 9117

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9117

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SCHWARTZ, Russell Frank		2. DATE AND HOUR OF DEATH 9-6-68 3:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Haworth Co 63-00		C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		E. STREET AND NUMBER 205 MacAlpine Road			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-02	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Frank Schwartz		14. MOTHER'S MAIDEN NAME Ida Hardy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-5-42 to 2-22-46		16. SOCIAL SECURITY NO. 091-14-27-59		17. INFORMANT VA Hospital Records ADDRESS Baltimore, Maryland 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Probable Brain Abscess Metastasis Tumor not R/O Carcinoma of Lung Resected 6-11-66 Broncho Pneumonia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 163X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from June 1, 19 68 to September 6, 19 68 , that (X) (we) last saw the deceased alive on September 6, 19 68 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (XX) view the body after death.					
23A. SIGNATURE David N. Marine		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) DAVID N. MARINE MD	
23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-68		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore, Md					
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Humboldt-Slack ADDRESS Ellicott City Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9118

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9118

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SPERLING, WALTER		2. DATE AND HOUR OF DEATH 9-6-68 9:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND , WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GEN. HOSP. 43		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2320 Annapolis Road			
5. SEX M	6. RACE N W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-02	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) WETA, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAKE SPERLING		14. MOTHER'S MAIDEN NAME Lillian ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-5113		17. INFORMANT Charles A. Price, 501 Cleveland Road	
18. 571.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Massive Hematemesis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Larson's Cirrhosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years			
19. 581.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 8-23		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8-23 19 68 to 9-6 19 68 , that (I) (we) lost saw the deceased alive on 9-6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Donald M. Wood, MD		23B. DATE SIGNED 9-6-68			
23C. PHYSICIAN'S NAME (Type) DONALD M. WOOD		23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 Sept. 68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.					

23rd January 1942

11-22-42

Received

Received

Unknown

212-02-5113 Charles A. Price, 301 Cleveland St.,
Washington Heights, N.Y.

Thomas H. Hines

William C. Hines

South Baltimore General Hospital

Woodlawn Cemetery

Graves

Baltimore, Md.

Marley Funeral Home, 6200 E. Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 9119	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
ARTHUR SPERSCHNEIDER		9/5/68 8:22 PM		NORTH CHARLES GENERAL HOSPITAL		SPERSCHNEIDER, ARTHUR MEDWALLENSTEIN	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, ADDRESS OR LOCATION)		A. STATE		B. CITY OR TOWN	
NORTH CHARLES GENERAL HOSPITAL		49 HOSPITAL		MD		BALTIMORE	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11-12-1891	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Self employed		Floor finishing		GERMANY		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
MYLIUS SPERSCHNEIDER		HELMMA BAUMAN		No		091-07-5390A	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
WIFE		SAME		199.1 I			
				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
				(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
				ANTECEDENT CAUSES			
				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
				199.2 II			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8-22 1968 to Sept. 5 1968, that (I) (we) lost saw the deceased alive on Sept. 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did-not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
B. Paulino m.d.				Sept. 5, 1968			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Adoracion B. Paulino m.d.				North Charles General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9/9/68		St Johns Luth Cem		Parkville, Balto Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 9 1968		Robert E. Taylor		C.F. EVANS & SON		8802 Harford road	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 9120	
1. NAME OF DECEASED (Type or Print)		THOMAS F. HAWES JR. HAWES, THOMAS F.		2. DATE AND HOUR OF DEATH		SEPTEMBER 4, 1968 11:50A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL 40				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 53-00			
5. SEX MALE				6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 01/21/13		9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS HAWES		14. MOTHER'S MAIDEN NAME DAISEY REED HAWES		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE	
16. SOCIAL SECURITY NO. 213-09-7987		17. INFORMANT ST. AGNES HOSPITAL RECORDS		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 4 19 68 to SEPTEMBER 4 19 68, that (I) (we) last saw the deceased alive on SEPTEMBER 4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE M. Alvarez 23B. DATE SIGNED SEP 9 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 23C. PHYSICIAN'S NAME (Type) M. ALVAREZ 23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES. 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 9/7/68 24C. NAME OF CEMETERY or CREMATORY GOOD SHEPHERD 24D. LOCATION ELLICOTT CITY MD. 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968 25B. NAME OF REGISTRAR Robert E. Farber 25C. FUNERAL DIRECTOR HIGDON BATHOM SLACK, ELLICOTT CITY MD.	

Birth Certificate of Deceased and Widow's
affidavit 8-5-69 M.H.

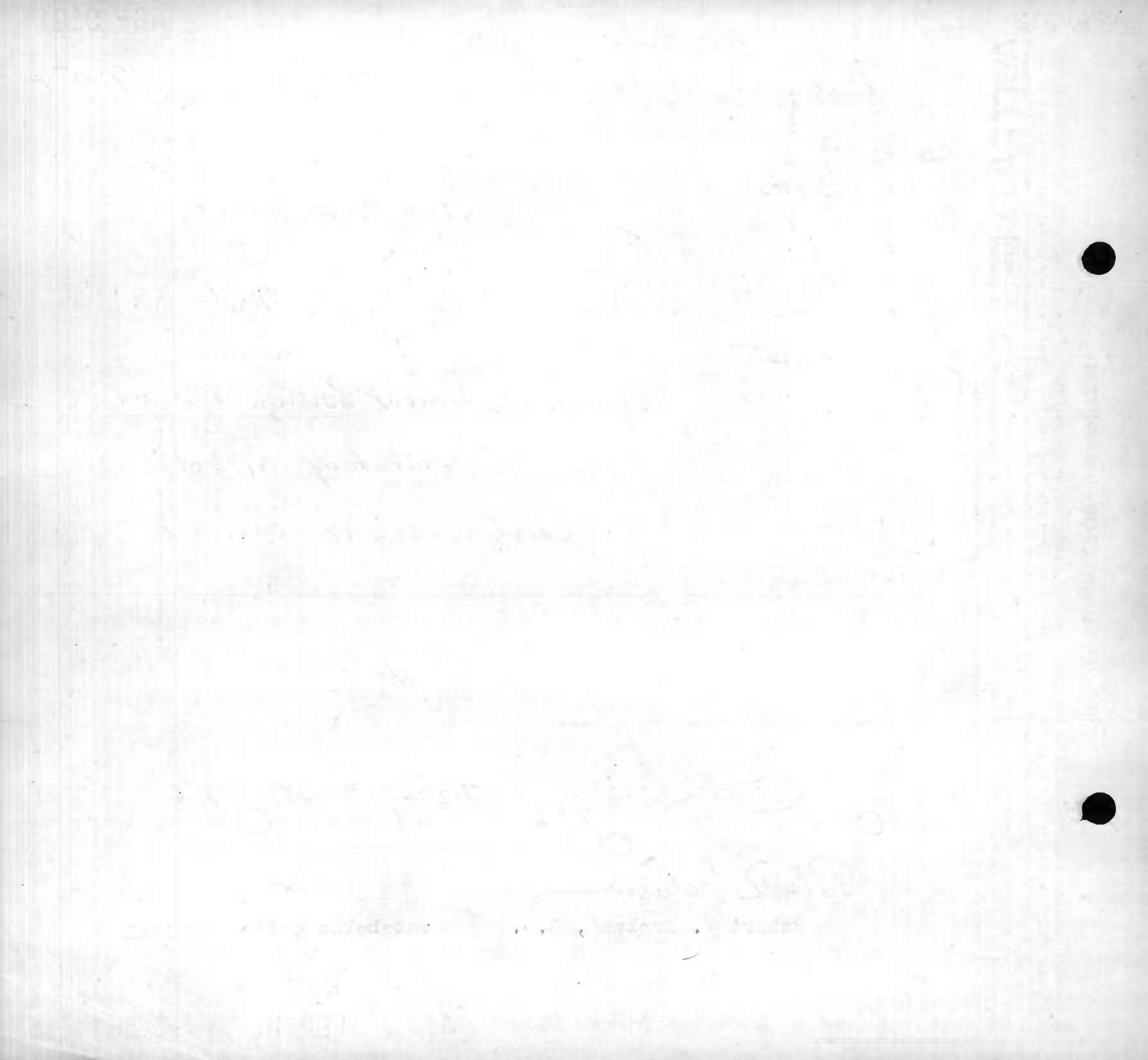
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9121 CERTIFICATE OF DEATH

REG. NO. 68- 9121

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Bovenza, Audrey A.</i>		2. DATE AND HOUR OF DEATH <i>9/6/68 9:15 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello</i>		E. STREET AND NUMBER <i>1538 William Street</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/7/11</i>	9. AGE (In years last birthday) <i>57</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Enatt</i>		14. MOTHER'S MAIDEN NAME <i>? unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no.</i>		16. SOCIAL SECURITY NO. <i>218-05-6426</i>		17. INFORMANT <i>Vincent Bovenza</i> ADDRESS <i>1538 William Street</i>	
18. <i>4369 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF:		(B) <i>Cerebrovascular accident</i> DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____					
19. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <i>7/22</i> 19 <i>68</i> to <i>9/6</i> 19 <i>68</i> , that (I) <u>we</u> last saw the deceased alive on <i>9/6</i> 19 <i>68</i> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert W. Ireland</i>		23B. DATE SIGNED <i>9/6/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>Robert W. Ireland, M.D.</i>		23D. ADDRESS <i>Montebello State Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sept. 10/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>	
25C. FUNERAL DIRECTOR <i>James McCully</i>		25D. ADDRESS <i>130 E. Fort Ave</i>			

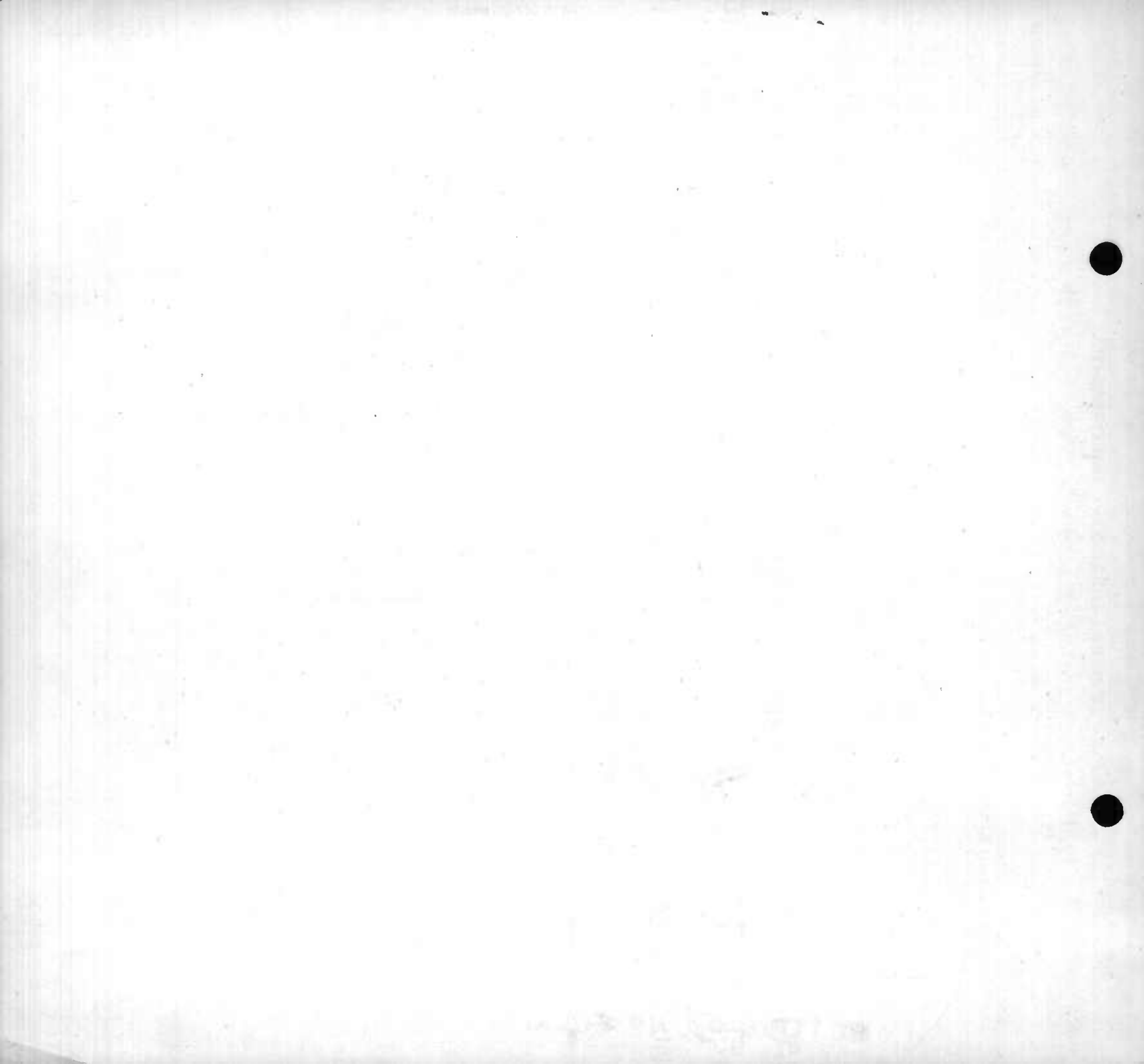


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 9122					REG. NO. 68- 9122				
BIRTH NO. 68-20303					2. DATE AND HOUR OF DEATH 22 Oct 1968 4:15 P.M.				
1. NAME OF DECEASED (Type or Print) Baby Girl Powell					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Univ. of Md. Hosp- 38					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 15-04				
5. SEX F 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 21 Oct 68 9. AGE (In years last birthday) 21 0. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 21 0				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME James Nixon					14. MOTHER'S MAIDEN NAME Cynthia Powell				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO.				
17. INFORMANT Jane C. McCaffrey M.D.					ADDRESS Univ. of Md. Hosp				
18. 773.0 II DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYALINE MEMBRANE DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) YES					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 21 Oct 19 68 to 22 Oct 19 68, that (I) (we) last saw the deceased alive on 22 Oct 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jane L. McCaffrey M.D.					23B. DATE SIGNED 22 Oct 68				
23C. PHYSICIAN'S NAME (Type) Jane L. McCaffrey M.D.					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) DEC 12 1968					24B. DATE				
24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1968					25B. NAME OF REGISTRAR Robert E. Taylor				
25C. FUNERAL DIRECTOR					25D. ADDRESS				

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

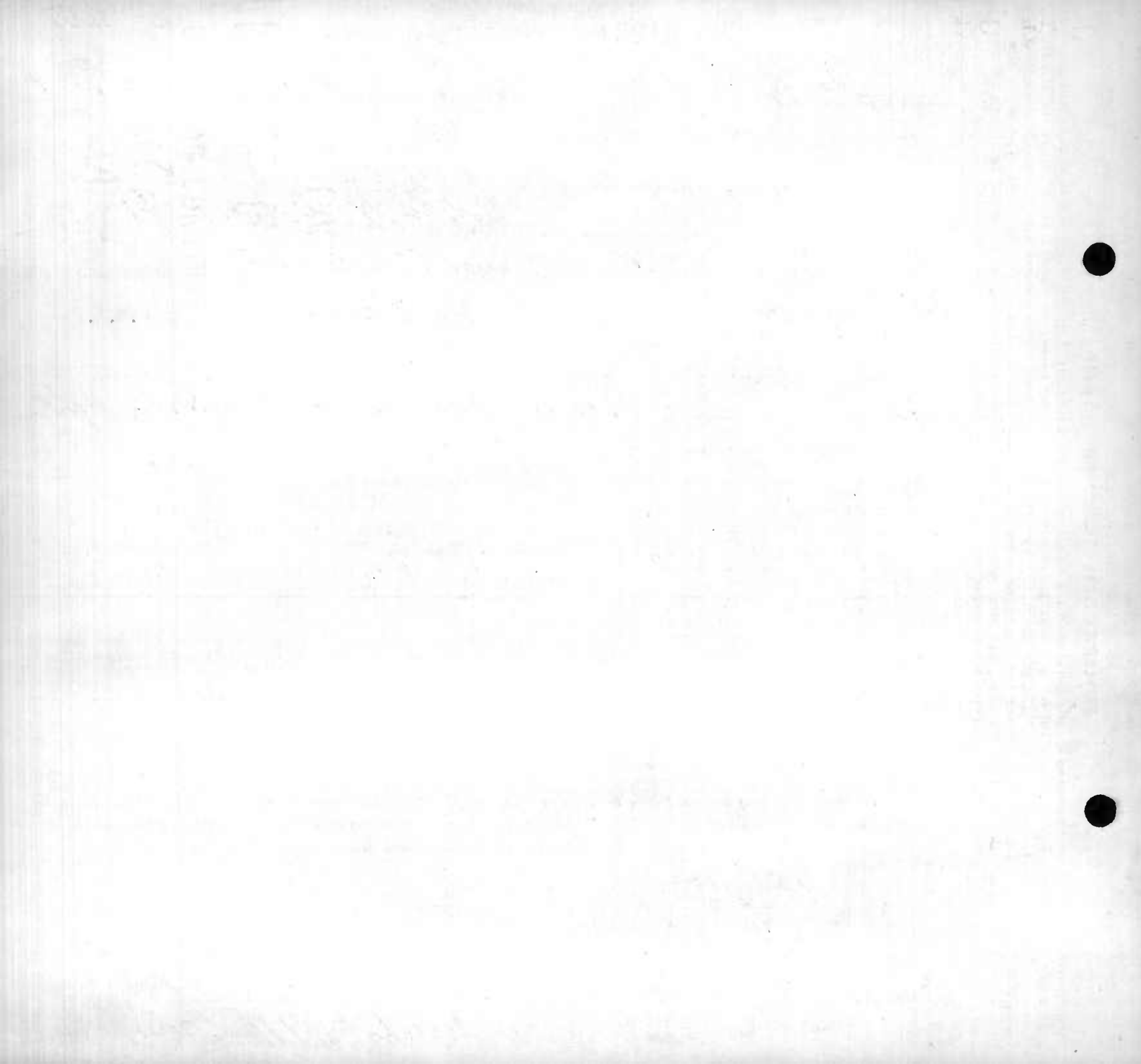
68- 9123 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9123

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Harry Burdette</i>		2. DATE AND HOUR OF DEATH <i>9-4-68</i> <i>5⁵⁰</i> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>12-05</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>			C. CITY OR TOWN <i>Baltimore</i> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>1622 N Calvert St</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 27/1883</i>	9. AGE (In years lost birthday) <i>85</i>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret Carpenter</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>413-</i>		17. INFORMANT <i>Ann Hevisler 30 Fullerton Hgts</i>	
18. <i>189.0 I</i> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bilateral lobar pneumonia</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Kidney tumor, possible malignancy</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <i>Senility, dehydration, hypoventilation</i>			
180 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/19/68</i> 19 to <i>9/3/68</i> 19, that (I) (we) last saw the deceased alive on <i>9/3/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Champer</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>DR. YING-SER CHAN</i>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/6/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Garden of Faith</i>	
24D. LOCATION (City, town, or county) <i>Balto Co. Md.</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Loessha Farkner</i>	
				ADDRESS <i>7401 Pickens Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9124 CERTIFICATE OF DEATH

REG. NO. 68- 9124

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WALTER KULESZA (KULES)		2. DATE AND HOUR OF DEATH SEPTEMBER 4, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS 1-YES 03 NO <input type="checkbox"/>	
		E. STREET AND NUMBER 604 S. PORT ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25 1889	9. AGE (In years last birthday) 79 YRS	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10B. KIND OF BUSINESS OR INDUSTRY GOETZ MEAT CO.		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN ?		14. MOTHER'S MAIDEN NAME BOLESZAWA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES ARMY WWI 215-01-0445A		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ALICE KULESZA 604 S. PORT ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 491X I ENOPHYSEA PULMONARY		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC BRONCHITIS - BRONCHIECTASIS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: APR			
(C) ART					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 3-26X II ARTERIOSCLEROTIC HEART DISEASE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1962 to Sept 4 1968 , that (I) (we) last saw the deceased alive on Sept 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED Sept. 6-68		23C. PHYSICIAN'S NAME (Type) ANDREW LEMISCHKA MD	
23D. ADDRESS 2608 E. BALTIMORE ST - BALTO, MD		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9.9.1968	
24C. NAME OF CEMETERY or CREMATORY Holy ROSARY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE Co., MD.		25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		25D. ADDRESS 2525 FLEETS.	

C-524

68- 9125 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9125

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ARTHUR

CONGLETON

2. DATE OF DEATH

Known ☐ Estimated ☒

Month

Day

Year

Hour

August 27, 1968

12:30 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00646 Washington Boulevard

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

August 27, 1968

12:30 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

B. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

June 23, 1902

10. AGE (In years)

lost birthdate 56

Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF

WHAT COUNTRY?

USA

E. STREET AND NUMBER

646 Washington Boulevard

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Bertha Denton

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT ADDRESS John W Congleton 3722 Pennington Ave # 26

19. CAUSE OF DEATH	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>Pulmonary Tuberculosis</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>	

20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No)
		No
<p>22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.</p>	<p>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?</p>
<p>22D. TIME OF INJURY (APPROX.)</p>	<p>22E. INJURY OCCURRED</p>	<p>22F. HOW DID INJURY OCCUR?</p>

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from:
<p>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE: <i>Werner U. Spitz</i> M.D.</p> <p>EXAMINER'S NAME (Type): Werner U. Spitz M.D.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED: 8/27/68</p>

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	9/7/68	Cedar Hill Cem	Ritchie Hwy AA Co Md
25A. DATE RECEIVED BY HEALTH DEPT	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
SEP 9 1968	Robert E. Finkbeiner	McCully F.H. 8/37	Patapsco Ave 21225

1915

1915

20

James H. [Signature]

McClure & [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9126
BIRTH NO. 68-16566		68- 9126 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY BOY LONG "B"		2. DATE AND HOUR OF DEATH 9-5-68 6:30P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Balt. Co.		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore, Inc.		C. CITY OR TOWN Fort Howard	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 12 Blank Avenue				
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-68	9. AGE (In years lost birthday) 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Bernard A. Long, Jr.		14. MOTHER'S MAIDEN NAME Gloria Mae Wheat		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	17. INFORMANT Bernard A. Long, Jr.	
				ADDRESS Fort 12 Blank Ave. Howard Md
18. 769.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Prematurity		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 776 X II		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9-2 19 68 to 9-5 19 68 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. Eufemio		M.D. DEGREE		23B. DATE SIGNED 9-5-68
23C. PHYSICIAN'S NAME (Type) J. EUFEMIO		23D. ADDRESS Sinai Hospital Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-6-68	24C. NAME of CEMETERY or CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR Howard H. Hubbard	
				ADDRESS 4107 Wilkens 21229

BAD BY - LENS 15

12 Blank Avenue
Fort Howard
Marion

9-2-68

Marion
Gloria

M W

Durham

Presumably

M.D.
M.D.

J. E. E. M. 10
J. E. E. M. 10

✓

9-2-68

9-2

9-2

9-2

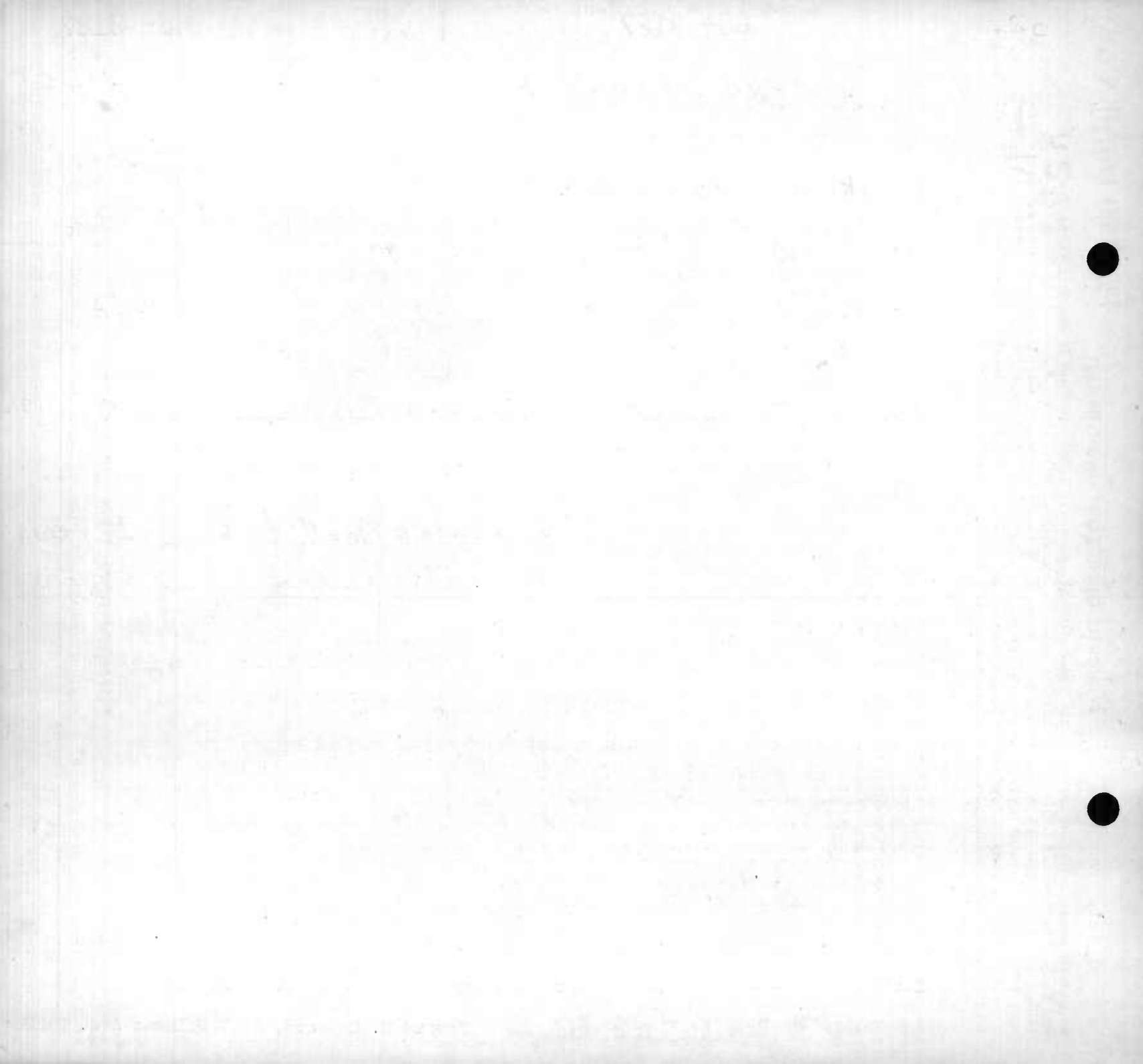
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9127 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9127

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Plotzke, Frank M.</u>		2. DATE AND HOUR OF DEATH <u>Sept. 5, 1968</u> <u>6:45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 Franklin Square Hospital</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1316 Seargent St.</u> <u>23</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-89</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Michael Plotzke</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-2198</u>		17. INFORMANT <u>Eva Plotzke, 1316 Seargent St.</u>	
18. <u>25-0-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>cardiac Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes mellitus 5 years</u> <u>Hypertension 5 years</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>260X II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1968</u> to <u>Sept. 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept. 5, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hyung Kon Lee, M.D.</u> OEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Hyung Kon Lee, M.D.</u> OEGREE				23D. ADDRESS <u>100 N. Calhoun St. Baltimore, Md.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-9-68</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9128		BALTIMORE CITY HEALTH DEPARTMENT		68- 9128	
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Selby, George</i>		George L. Selby (Selba)		2. DATE AND HOUR OF DEATH <i>9/5/68</i> <i>2:40</i> a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE CITY</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN <i>BALTIMORE</i> INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>		
			E. STREET AND NUMBER <i>1610 NORTH CAROLINE STREET 21213</i>		
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-26-98</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>City of Baltimore</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>JOHN A. SELBY</i>			
14. MOTHER'S MAIDEN NAME <i>ANNIE BOWEN</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>218-03-5426A</i>		17. INFORMANT (Son) <i>Baltimore, Md. 21213</i> <i>Mr. John A. Selba, 1610 N. Caroline St.</i>			
18. <i>486X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Chronic Obstructive Pulmonary Disease years</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>493X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 5</i> 19 <i>68</i> to <i>Sept. 5</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Sept. 5</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David H. Katz, M.D.</i> OEGREE				23B. DATE SIGNED <i>9/5/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DAVID H. KATZ</i> OEGREE				23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/9/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1968</i>			
24F. NAME OF REGISTRAR <i>Robert E. Tarkenton</i>		24G. FUNERAL DIRECTOR <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>			

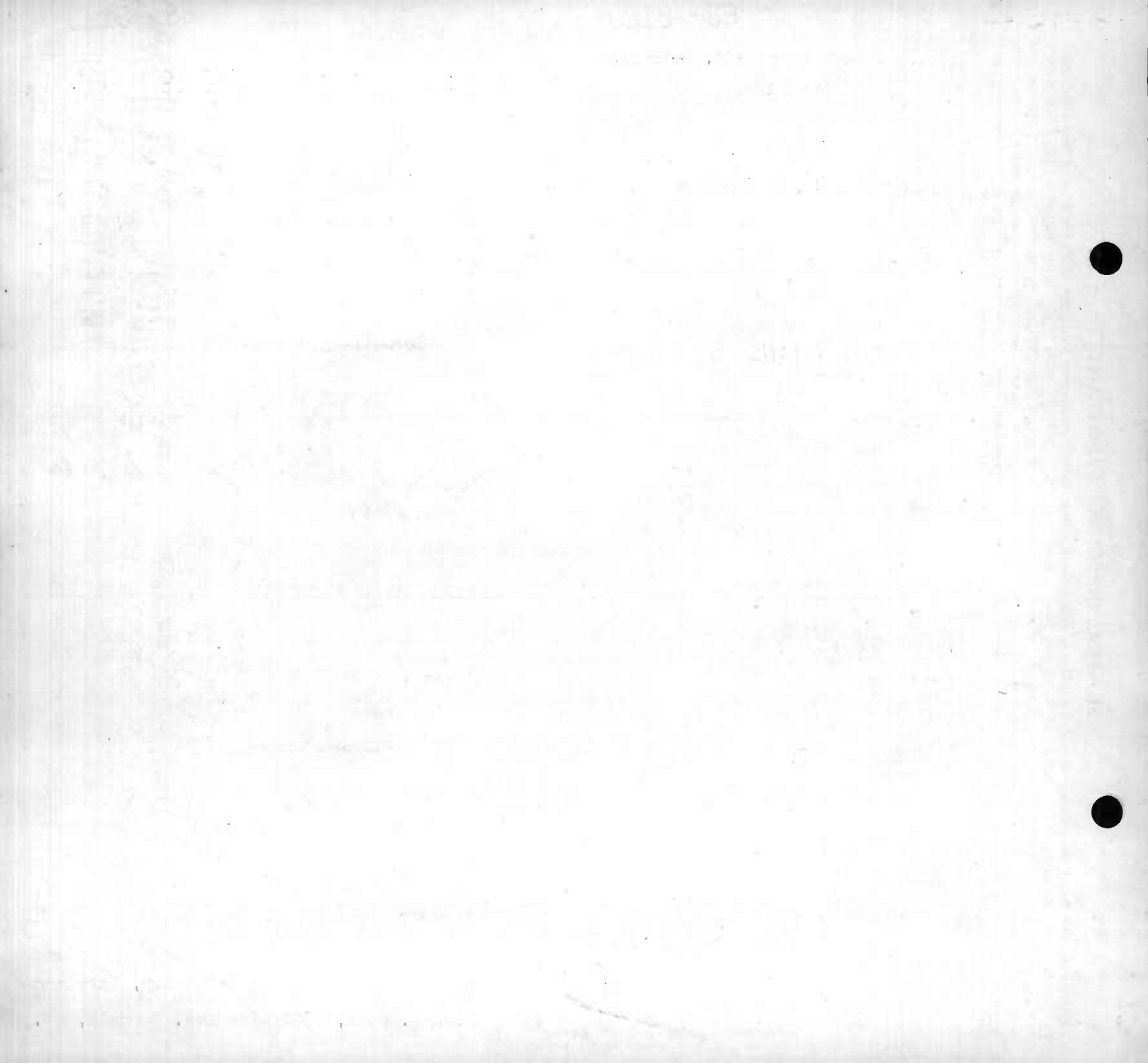
52 551
HCO. 70122

No

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 9129				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9129	
1. NAME OF DECEASED (Type or Print) FRANCES C. POLONSKI				2. DATE AND HOUR OF DEATH Sept. 5, 68 12:01 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) North Charles General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2109 Bank Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-05	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanislaus Wisniewski			14. MOTHER'S MAIDEN NAME Pa. Veronica Kropkowski				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?	17. INFORMANT Daughter - Betty -		ADDRESS same		
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral Pulmonary Emboli				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 465X II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-5 1968 to 9-5 1968 , that (I) (we) last saw the deceased alive on 9-5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Theodore NIZNIK, M.D.				23B. DATE SIGNED 9-5-68			
23C. PHYSICIAN'S NAME (Type) THEODORE NIZNIK, M.D.		23D. ADDRESS North Charles Gen. Hosp. Bldg.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/68	24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9130

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mahoney Georgia B.

2. DATE AND HOUR OF DEATH

Sept. 6th '68 2:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital of Md.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INS. OF CITY LIMITS?

E. STREET AND NUMBER

2803 Garrison Blvd.

5. SEX

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Horace Bowers

14. MOTHER'S MAIDEN NAME

Mary A. Rogers

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Minnie Mahoney, 5549 Link Ave. 21227

18. *440.9 I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) *Serile encephalitic operation of*

DUE TO, OR AS A CONSEQUENCE OF:

(C) *Sigmoid diverticulosis,*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (*this hospital*) attended the deceased from *July 22* 19*68* to *Sept. 6* 19*68*.
that (I) (*we*) lost saw the deceased alive on *Sept. 6th* 19*68* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (*We*) (*did*) (*did not*) view the body after death.

23A. SIGNATURE

Part M. Hyung Kyoun Part

Attending ☐ Phys.

Med. Director ☐

Staff ☒ Phys.

23B. DATE SIGNED

Sept. 6th '68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

Lutheran Hosp. of Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

9-9-1968

Loudon Park Cemetery

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 9 1968

Robert E. Jackson

Howard H. Hubbard, 4107 Wilkens Ave. 21229

Maryland Group

Washington Hospital of the

Mr. [illegible]

Baltimore

also [illegible]

10/12/08 88

✓ W F

Public Association, [illegible]
[illegible] [illegible]
[illegible] [illegible]

10/12/08

10/12/08 88

Thyroid [illegible]
[illegible] [illegible]

Washington Hosp. of the
[illegible] [illegible]

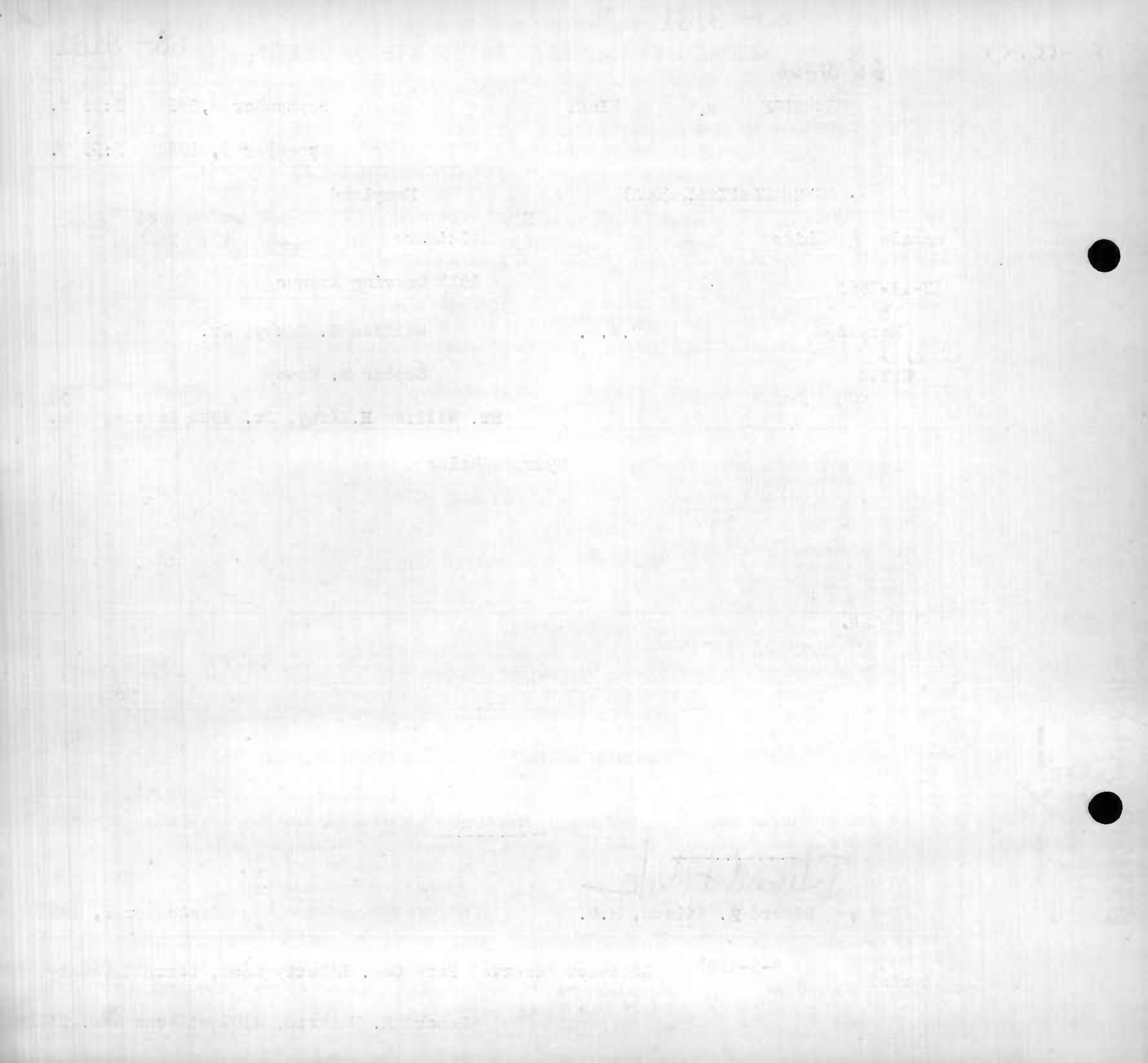
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9131

BIRTH NO. 65-31260

REG. NO.

1. NAME OF DECEASED (Type or Print) MICHELLE R. KIRBY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 6, 1968 Hour 5:55 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 6, 1968 5:55 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-13-1965		10. AGE (In years lost birthday) 2 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. William H. Kirby, Jr.		ADDRESS 21230 Deering Ave.	
19. 347.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hydrocephalus (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 344.2 II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Edward P. Wilson, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 7, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-1968	
24C. NAME OF CEMETERY or CREMATORY Lakeview Memorial Park Cem.		24D. LOCATION (City, town, or county) (State) Liberty Road, Carroll County, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9132

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE E. SMITH

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 5, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 5, 1968

3:22 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

3/14/1889

10. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1239 Carroll Street

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Smith

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bar tender

14B. KIND OF BUSINESS OR INDUSTRY

Barman

15. MOTHER'S MAIDEN NAME

Mary ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

✓

18. INFORMANT

Mrs Sadie Smith

ADDRESS

above

19.

412.4 I

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/9/68

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

24D. LOCATION

(City, town, or county)

(State)

4300 Old Frederick Rd. Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 9 1968

25B. NAME OF REGISTRAR

Robert E. Farkner

25C. FUNERAL DIRECTOR

John J. Cowan son Dne. Hollins

ADDRESS

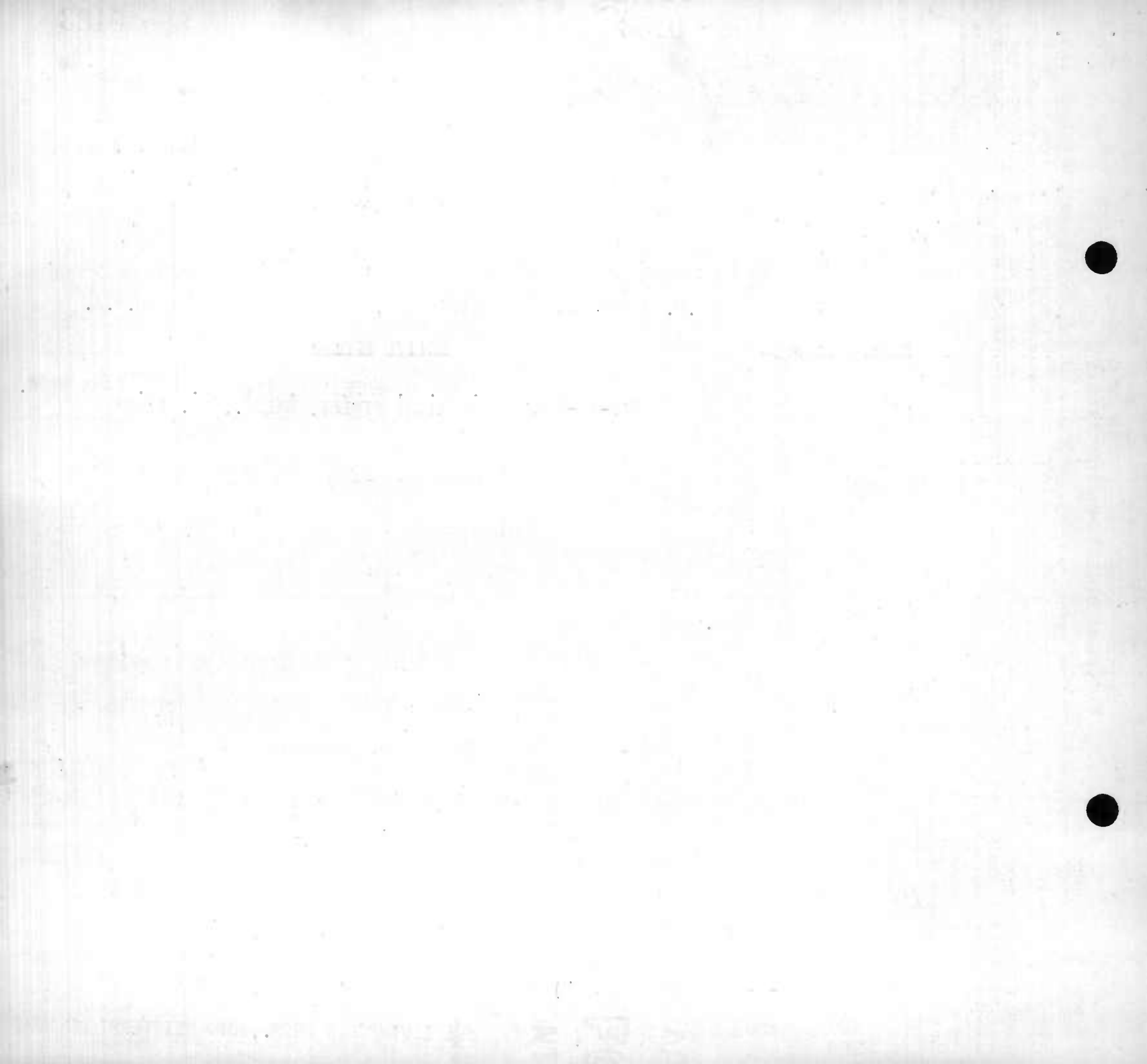
901 St.

Christ J. Light

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

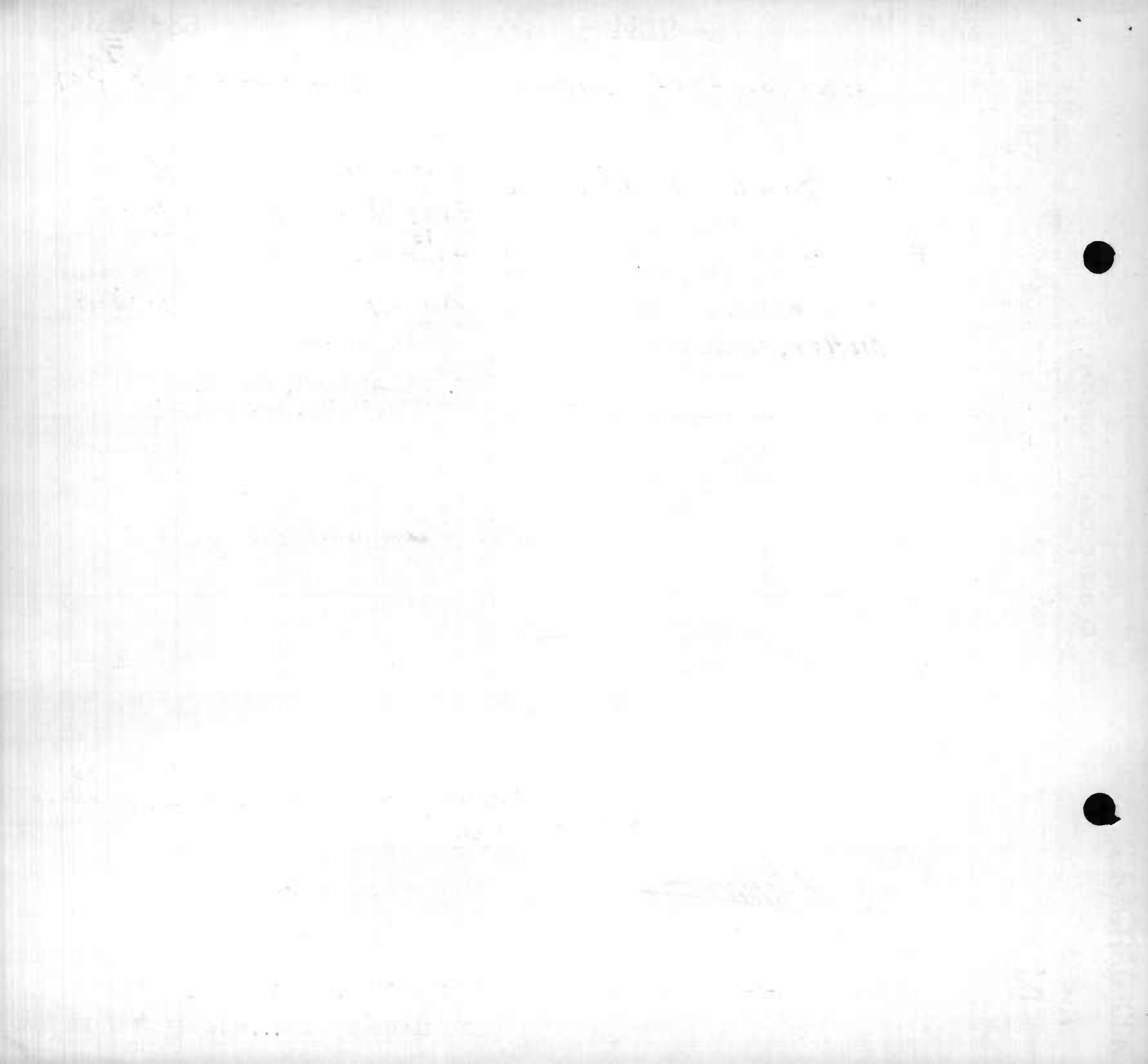
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9133
68- 9133 CERTIFICATE OF DEATH				
BIRTH NO. 1. NAME OF DECEASED (Type or Print) CHARLOW IRENE HESTER		2. DATE AND HOUR OF DEATH 9/3/68 10¹⁵ P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt C. CITY OR TOWN Balt INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3301 DORITAN ROAD		
5. SEX FEMALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 54	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT		11. BIRTHPLACE (State or foreign country) BALTI MORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME SAMUEL CHARLOW		14. MOTHER'S MAIDEN NAME MOLLIE BECKER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-2074		17. INFORMANT MR. WM. H. ENGELMAN, 1845 MD. NAT. BANK BLDG. 10 LIGHT STREET, BALTO., MD. 21202
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 193X I CAUSE OF DEATH DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 194X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: (B) Thyroid cancer DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 h. 18 months.
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9 AM Sept 3 1968 to 10 PM 9/3 1968, that (I) (we) last saw the deceased alive on 9/3/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Daniel Greenwald MD		23B. DATE SIGNED 9/3/68		23C. PHYSICIAN'S NAME (Type) DANIEL GREENWALD
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-5-68		24C. NAME of CEMETERY or CREMATORY (AITZ CHAIN) ANSHE EMUNAH
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR SOL LEVINSON, & BROS., 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-105				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9134	
68- 9134				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ABRAMS, ANNA				2. DATE AND HOUR OF DEATH 9-6-68 8⁵⁰ PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: H/2 Sinai Hospital INC (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD B. COUNTY: Baltimore C. CITY OR TOWN: Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: 5036 Pembroke Ave # 15			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-1-03	9. AGE (in years last birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10B. KIND OF BUSINESS OR INDUSTRY REGISTERED		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME MILBY, SAMUEL AARON				14. MOTHER'S MAIDEN NAME ROSE VATOWITZ			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT MRS. TOBA WILENSKY, 1220 BLAIR MILL ROAD SILVER SPRING, MARYLAND 20910			
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 174X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 170X II				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiorespiratory failure (B) advance & widespread cd of breast (C) _____			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 170X II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-15-68 / 3:15 PM to 9-6-68 8⁵⁰ PM , that (I) (we) last saw the deceased alive on 9-6-68 8⁵⁰ PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. [Signature]				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-8-68		24C. NAME OF CEMETERY or CREMATORY DHR KNESSETH ISRAEL ANSHE SFARD		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9135

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT BRANCH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 5, 1968 11:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year September 5, 1968 11:30 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 12-15-1897		10. AGE (In years last birthday) 70 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTON BRANCH		14. STREET AND NUMBER 3458 Dolfield Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		14B. KIND OF BUSINESS OR INDUSTRY RETAIL STORE	
15. MOTHER'S MAIDEN NAME GITTEL ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS MRS. ANN BRANCH, 3458 DOLFIELD AVENUE	
19. E 965 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of Head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. E 981 X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) 1600 Blk. W. Lanvale Street (on street)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) Sept. 5, 1968 7:40 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during assault and robbery	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 6, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-8-68	
24C. NAME of CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

100-1112

Information on 100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

100-1112

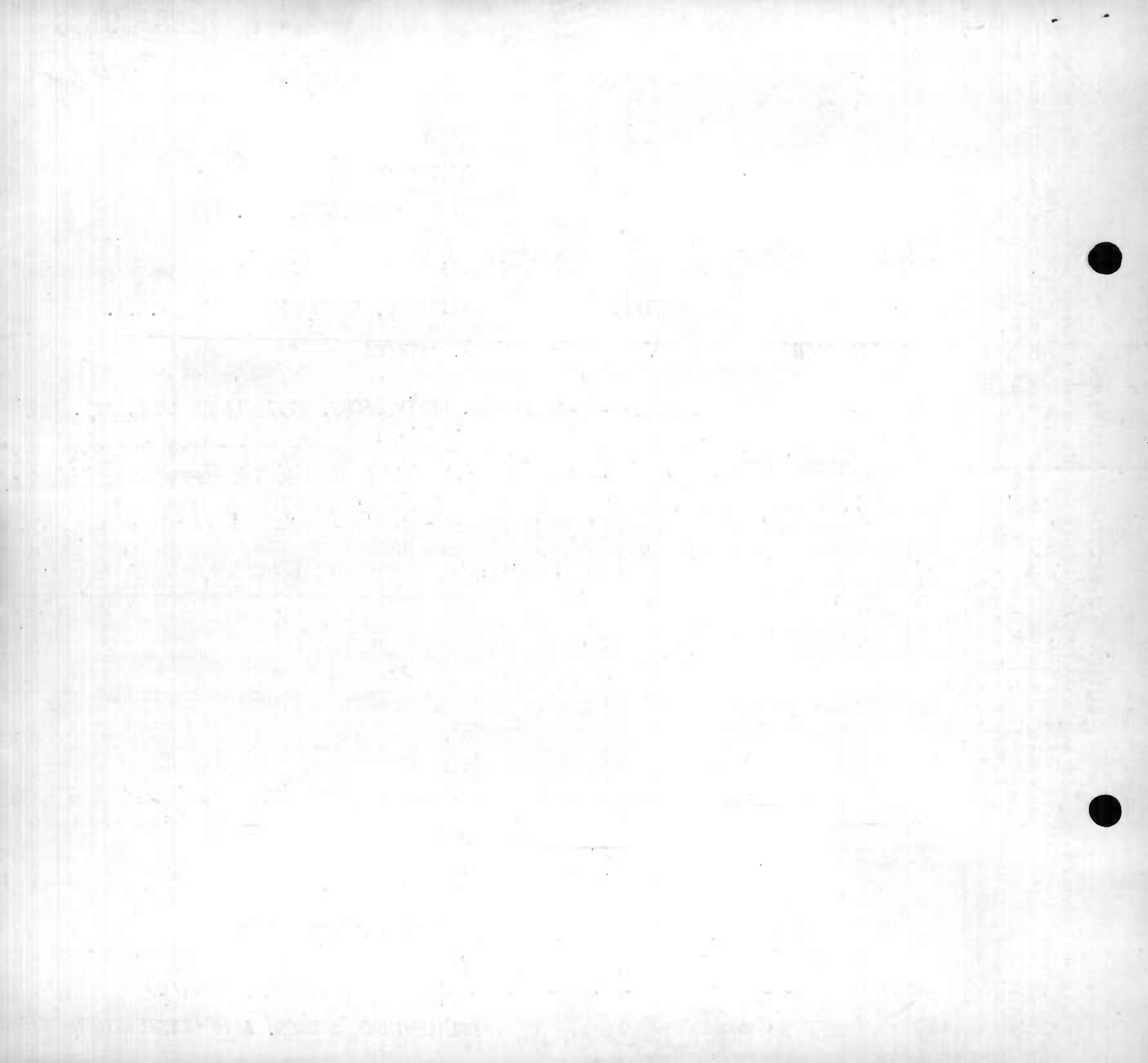
100-1112

100-1112

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

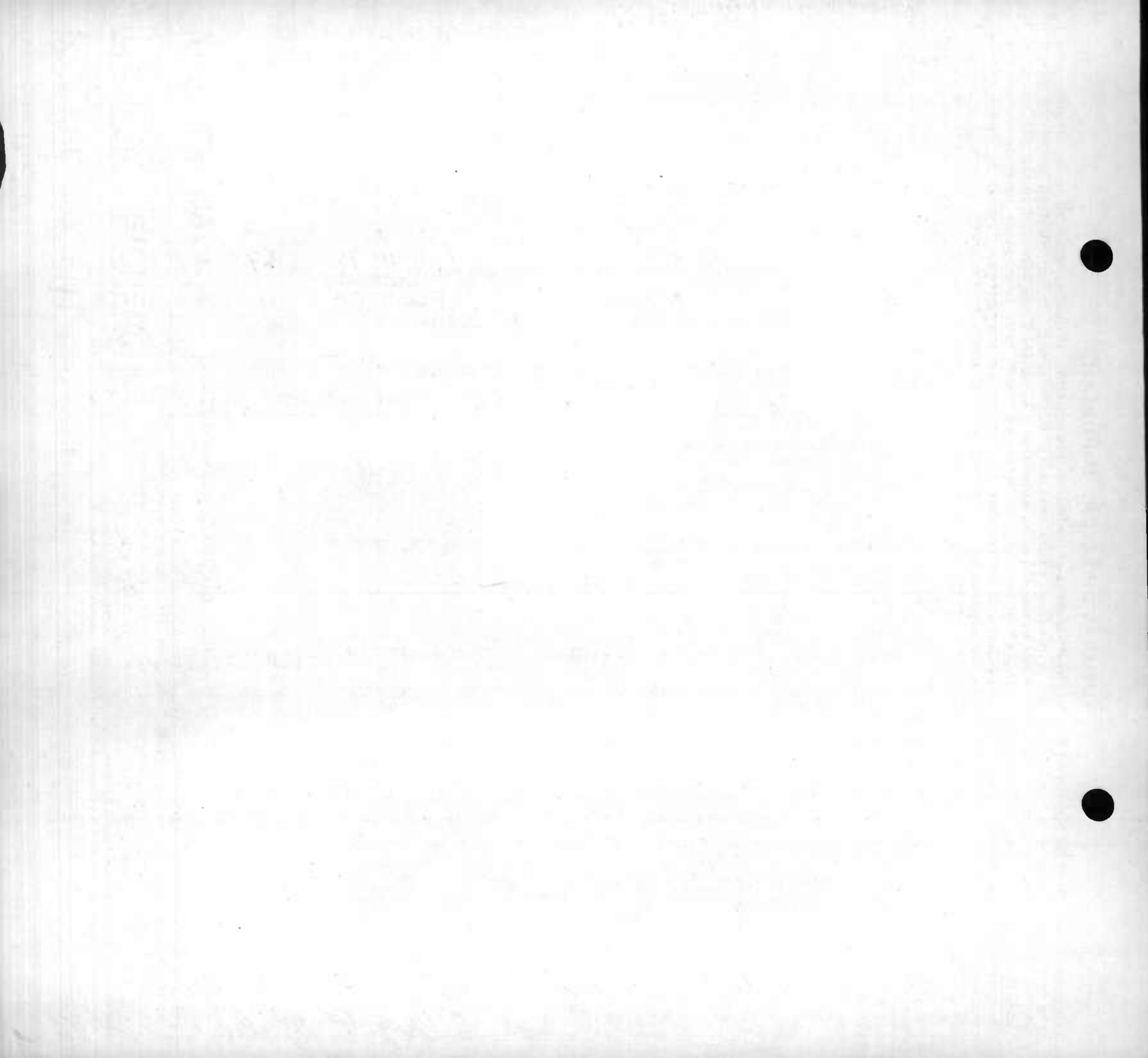
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 9136</u>
BIRTH NO. <u>15-200</u>				68- 9136
1. NAME OF DECEASED (Type or Print) <u>SACHS, MAYER</u>		2. DATE AND HOUR OF DEATH <u>9/5/68</u> <u>5:32 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BELVEDERE NURSING HOME - 90 HOUSE IN THE PINES</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS <input type="checkbox"/> YES <input type="checkbox"/> NO		
		E. STREET AND NUMBER <u>3737 CLARKS LANE, APT. 107</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1901</u>	9. AGE (In years last birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOSEPH SACHS</u>		
14. MOTHER'S MAIDEN NAME <u>REBECCA ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>578-07-2142A</u>		17. INFORMANT <u>MRS. BETTY SACHS, 3737 CLARKS LANE, APT. 107</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>162.1 I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTecedent CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>163 X II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Broncho PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA OF LUNG WITH 1 YEAR</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL METASTASES</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>163 X II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from <u>5/7/68</u> 19 to <u>9/5/68</u> 19, that (I) (we) last saw the deceased alive on <u>9/5/68</u> 19 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.				
23A. SIGNATURE <u>B. R. Shochet, MD</u>		23B. DATE SIGNED <u>9/5/68</u>		23C. PHYSICIAN'S NAME (Type) <u>BERNARD R. SHOCHET</u>
23D. ADDRESS <u>6804 PARK HEIGHTS AVENUE</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>9-8-68</u>		24C. NAME of CEMETERY or CREMATORY <u>MIKRO-KODESH-BETH ISRAEL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. 3010 REISTERSTOWN ROAD</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9137 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9137	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SAMUEL CARTER		2. DATE AND HOUR OF DEATH SEPT. 4, 1968 9:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 19-02		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 218 N. MOUNT STREET					
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/12/1899	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) FLORIDA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ?			
14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES			
16. SOCIAL SECURITY NO. 218-01-0194		17. INFORMANT UTAI RUANGWIT, M.D. FRANKLIN SQUARE H			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 II		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary edema & congestion DUE TO, OR AS A CONSEQUENCE OF: bilateral, severe (B) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: Renalized arteriosclerosis (C) Renalized arteriosclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 4, 1968 to Sept 4, 1968 , that (I) (we) last saw the deceased alive on Sept 4, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Utai Ruangwit, M.D.		23B. DATE SIGNED Sept 4, 1968		23C. PHYSICIAN'S NAME (Type) UTAI RUANGWIT, M.D.	
23D. ADDRESS FRANKLIN SQUARE HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-10-68		24C. NAME OF CEMETERY or CREMATORY Balto Nat Cem	
24D. LOCATION (City, town, or county) (State) Balto Md					
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR E. Gray P. Miller	
25D. ADDRESS 2791					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9138

BIRTH NO.

REG. NO.

1. NAME OF DECEASED

(Type or Print)

DAVID HUDSON

2. DATE

Known ☒

Month

Day

Year

Hour

OF DEATH

Estimated ☐

9

4

68

4:45 a

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

OR INSTITUTION

South Balto. General Hospital D.O.A.

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

September

4

1968

4:45 a

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Colored

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

9-15-47

10. AGE (In years)

lost birthday

20

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3411 Park Heights Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

Milton Hudson

14A. USUAL OCCUPATION (Give kind of work done during most of working life. If retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Agnes Briscoe

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war, dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

217-46-2562

Milton Hudson - 2252 White Mt

19. E856.8

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Overdose of narcotics

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E874.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

9 ? 68 ? m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Overdose

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 4, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-10-68

24C. NAME OF CEMETERY or CREMATORY

Halls Cent GAO

24D. LOCATION (City, town, or county) (State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 9 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Choy Wilson / 1000 Beauty

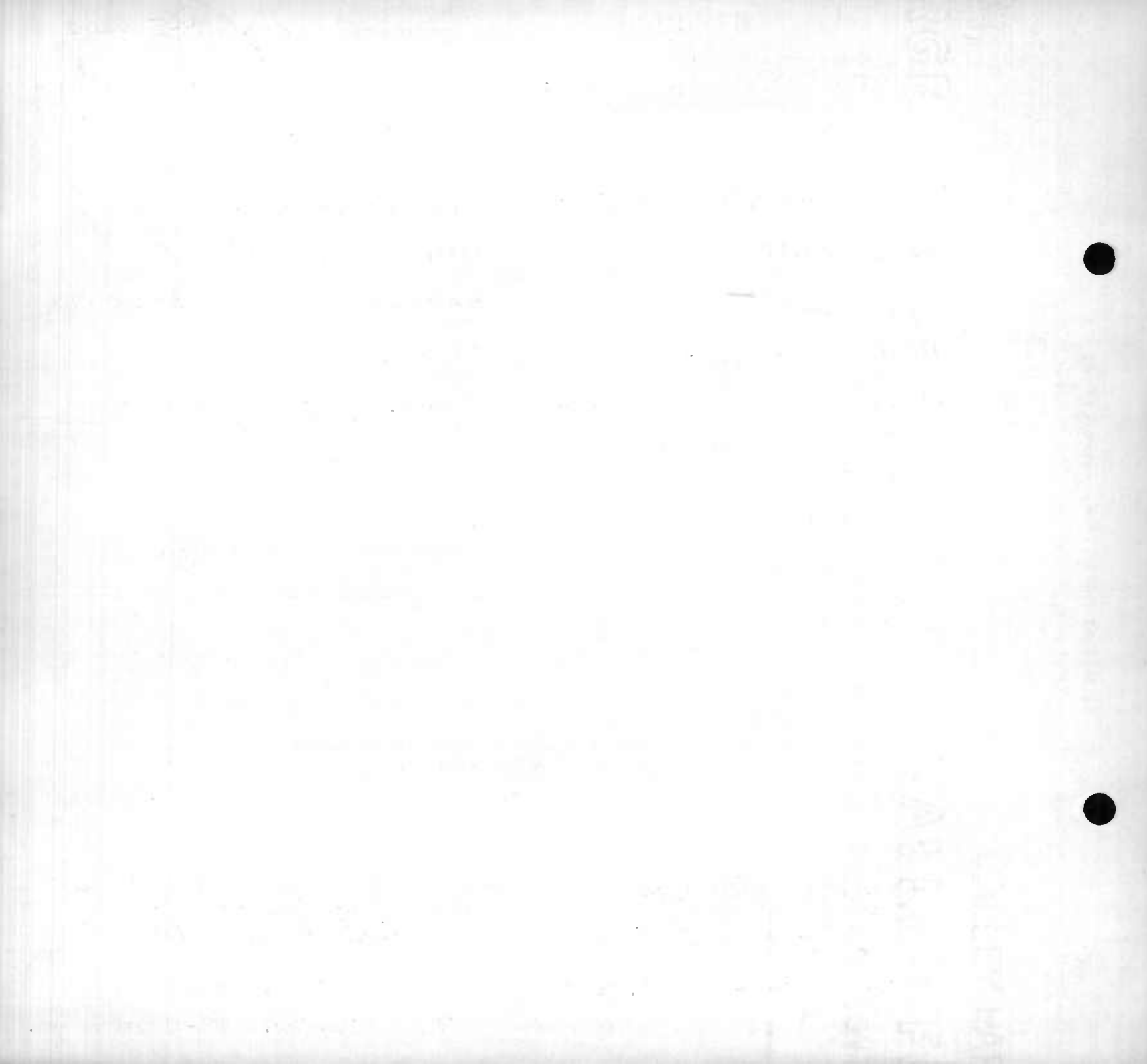
ADDRESS

C

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9139	
68- 9139				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES PATRICK NUESLEIN		2. DATE AND HOUR OF DEATH September 6/1968 9 10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 3922 GLENHURST Rd. 21222	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/1894	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Westren Electric		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME HENRY NUESLEIN		14. MOTHER'S MAIDEN NAME ELIZABETH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-1455		17. INFORMANT Henry J. Nueslein 3922 Glenhurst Road	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction Seven bilateral bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic heart disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 1 1968 to September 6 1968 , that (I) (we) last saw the deceased alive on September 6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique Oleusofen MD		23B. DATE SIGNED Sept 6/68		23C. PHYSICIAN'S NAME (Type) SHELDON C. KRAVITZ MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-10-1968		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus	
24D. LOCATION Baltimore, Maryland		24E. ADDRESS 6715 Parks Heights Ave. 15		24F. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Tankers		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250		68- 9140		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9140	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) HERMAN J. JACKSON			
2. DATE AND HOUR OF DEATH 9-4-68 8:15 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY				5. SEX MALE			
C. CITY OR TOWN BALTIMORE				6. RACE NERGO			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
E. STREET AND NUMBER 709 WEST BARRE STREET				8. DATE OF BIRTH 1-10-06			
9. AGE (in years last birthday) 62				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY JACKSON				14. MOTHER'S MAIDEN NAME LAURA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT BALTIMORE CITY HOSPITALS ADDRESS RECORDS: 4940 EASTERN AVENUE #21224				18. 162.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-16 19 68 to 9-4 19 68 , that (I) (we) last saw the deceased alive on 9-4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE R. Chris Stucky M.D.			
23B. DATE SIGNED 9-4-68				23C. PHYSICIAN'S NAME (Type) R. C. STUCKY M.D.			
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9-9-68				24C. NAME OF CEMETERY or CREMATORY Mt. Auburn			
24D. LOCATION (City, town, or county) Baltimore, MARYLAND				24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968				25B. NAME OF REGISTRAR Robert E. Taylor			
25C. FUNERAL DIRECTOR CHARLES A. RICE				25D. ADDRESS 661 BARRE ST.			

10-15

1113

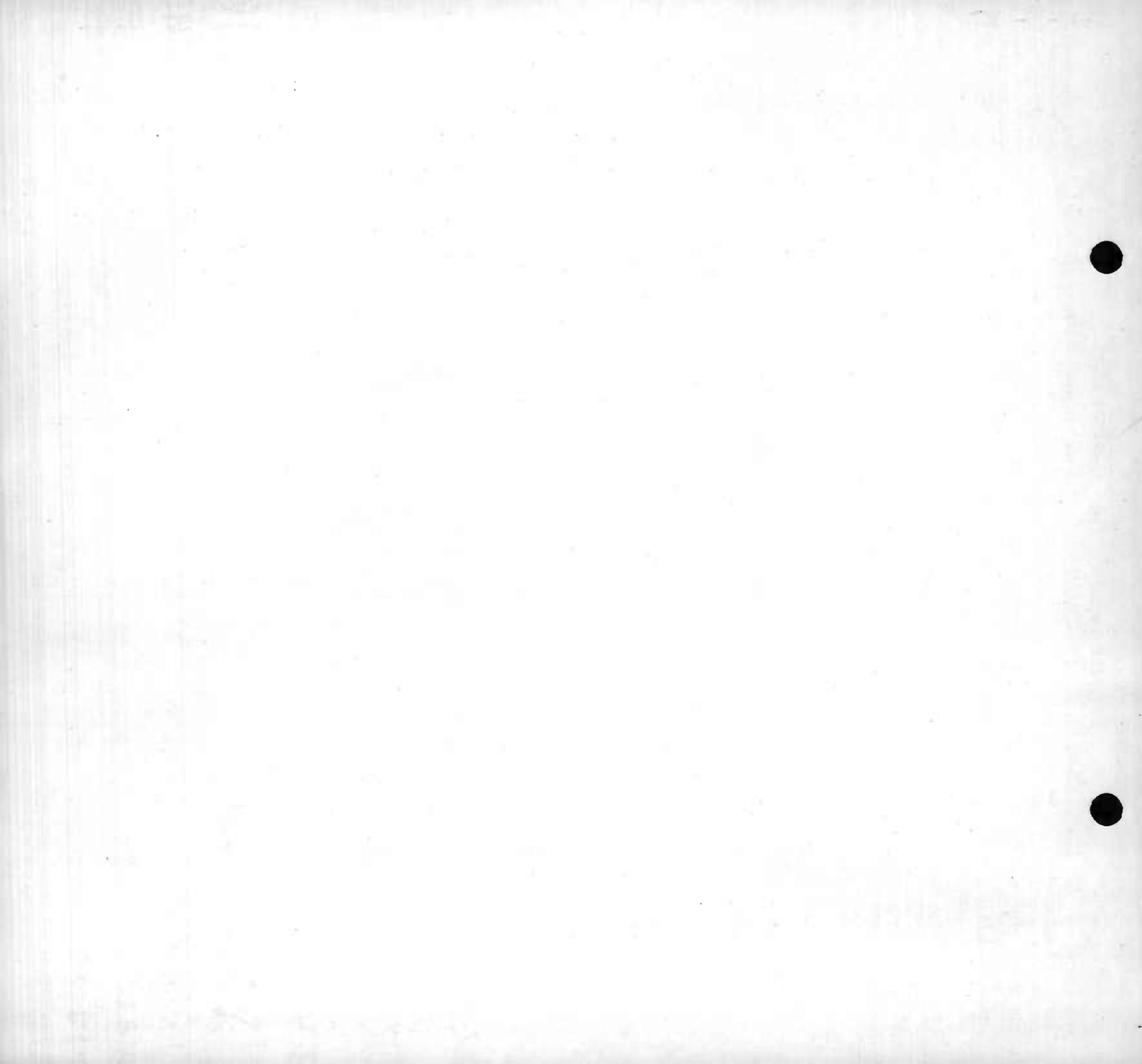
1113-23

1113-23

1113-23

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ETHEL POPE		2. DATE AND HOUR OF DEATH 8-30-68 11:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 16-02		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		E. STREET AND NUMBER 1310 WEST LAFAYETTE AVENUE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-89	9. AGE (In years last birthday) 79	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-1349-A		17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVENUE #21224	
18. 483 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 491 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Broncho pneumonia DUE TO, OR AS A CONSEQUENCE OF: (8) DUE TO, OR AS A CONSEQUENCE OF: (c) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-11-1968 to 8-30-1968 , that (I) (we) last saw the deceased alive on 8-30-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Christopher Stucky M.D. DEGREE				23B. DATE SIGNED 8-30-68	
23C. PHYSICIAN'S NAME (Type) R. C. STUCKY M.D. DEGREE				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-7-68		24C. NAME of CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR R. C. Stucky	
25C. FUNERAL DIRECTOR CHARLES A. RICE		25D. ADDRESS 661 W. BARR ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9142 CERTIFICATE OF DEATH

REG. NO. _____

68- 9142

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) EMMA FRANCES JOHNSON		2. DATE AND HOUR OF DEATH 9/3/68 4:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND. B. COUNTY 21217.		
5. SEX F			6. RACE NEGRO.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT VIRGIE ASTOR. ADDRESS AS ABOVE	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE (C) CEREBRAL THROMBOSIS. DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD. DUE TO, OR AS A CONSEQUENCE OF: (C) (L) CEREBRAL THROMBOSIS.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 4221 II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/23 19 68 to 9/3 19 68 , that (I) we last saw the deceased alive on 9/3 19 68 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 9/3/68.		23C. PHYSICIAN'S NAME (Type) JOHN. H. MATHER
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-7-68		24C. NAME of CEMETERY or CREMATORY Mt. Calvary
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968			25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR RICE, B. A. ADDRESS 661. W. Baltimore

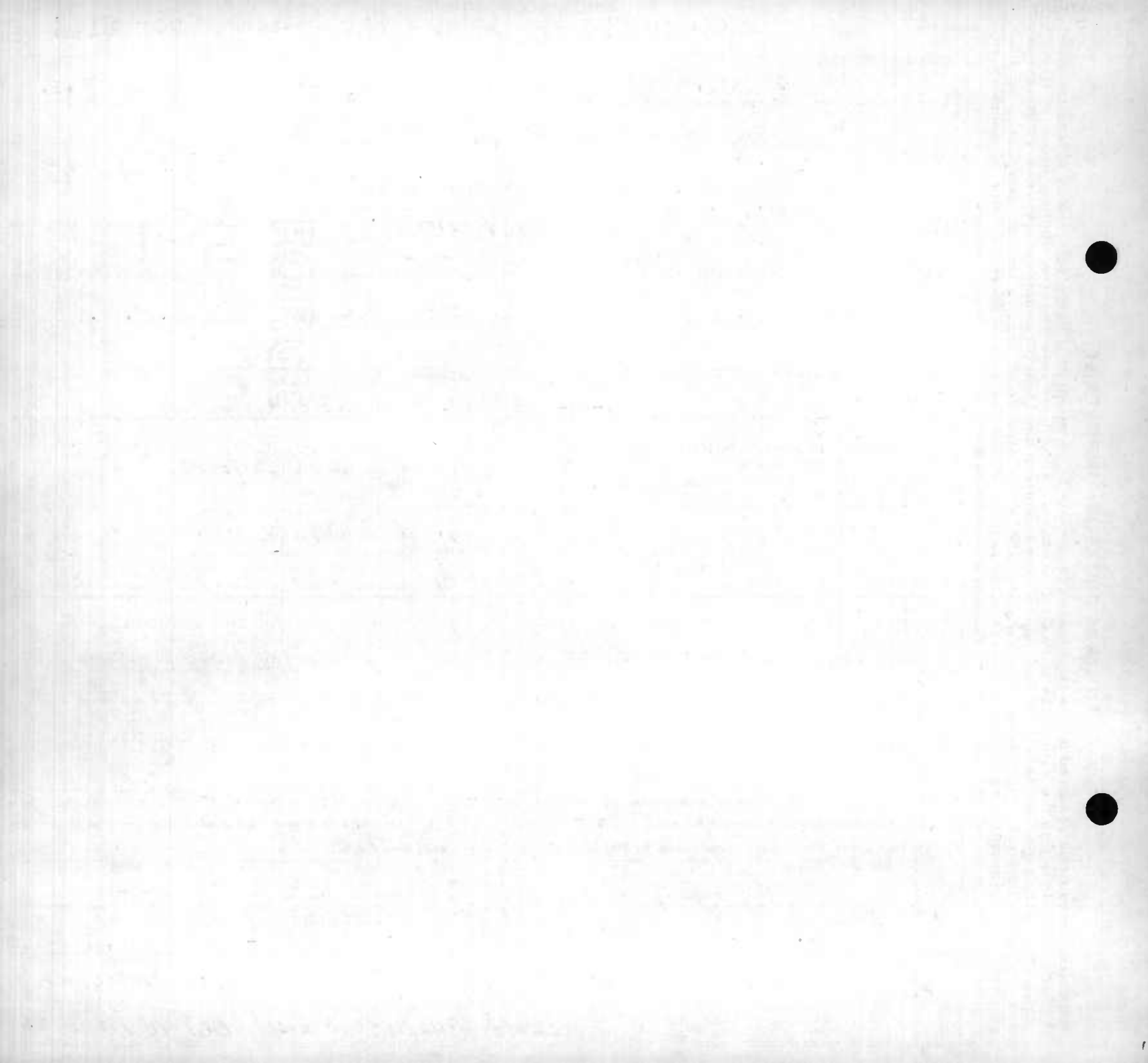
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9143 CERTIFICATE OF DEATH

REG. NO. 68- 9143

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Gregory, Mattie		2. DATE AND HOUR OF DEATH 9-4-68 11:35 <small>P.</small> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5-11-85		9. AGE (In years lost birthday) 84		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-54-4318		17. INFORMANT Mrs. Helen Turner (Daughter)	
ADDRESS		18. CAUSE OF DEATH 7-10-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Arteriosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Senility (C) 4-20-1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-6-68 at 1:00 p.m. 9-4-68 at 11:35 p.m.	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7-6-68 19 to 9-4-68 19, that (I) (we) last saw the deceased alive on 9-4-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Corpuz		23B. DATE SIGNED 9-4-68		23C. PHYSICIAN'S NAME (Type) Dr. Corpuz	
23D. ADDRESS Provident Hospital 1514 Division Street - Baltimore, Maryland		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-8-68	
24C. NAME OF CEMETERY or CREMATORY STOVAL		24D. LOCATION (City, town, or county) (State) STOVAL. NORTH CAROLINA		25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968	
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR CHARLES A. Rice		ADDRESS 661 W. Bane St.	

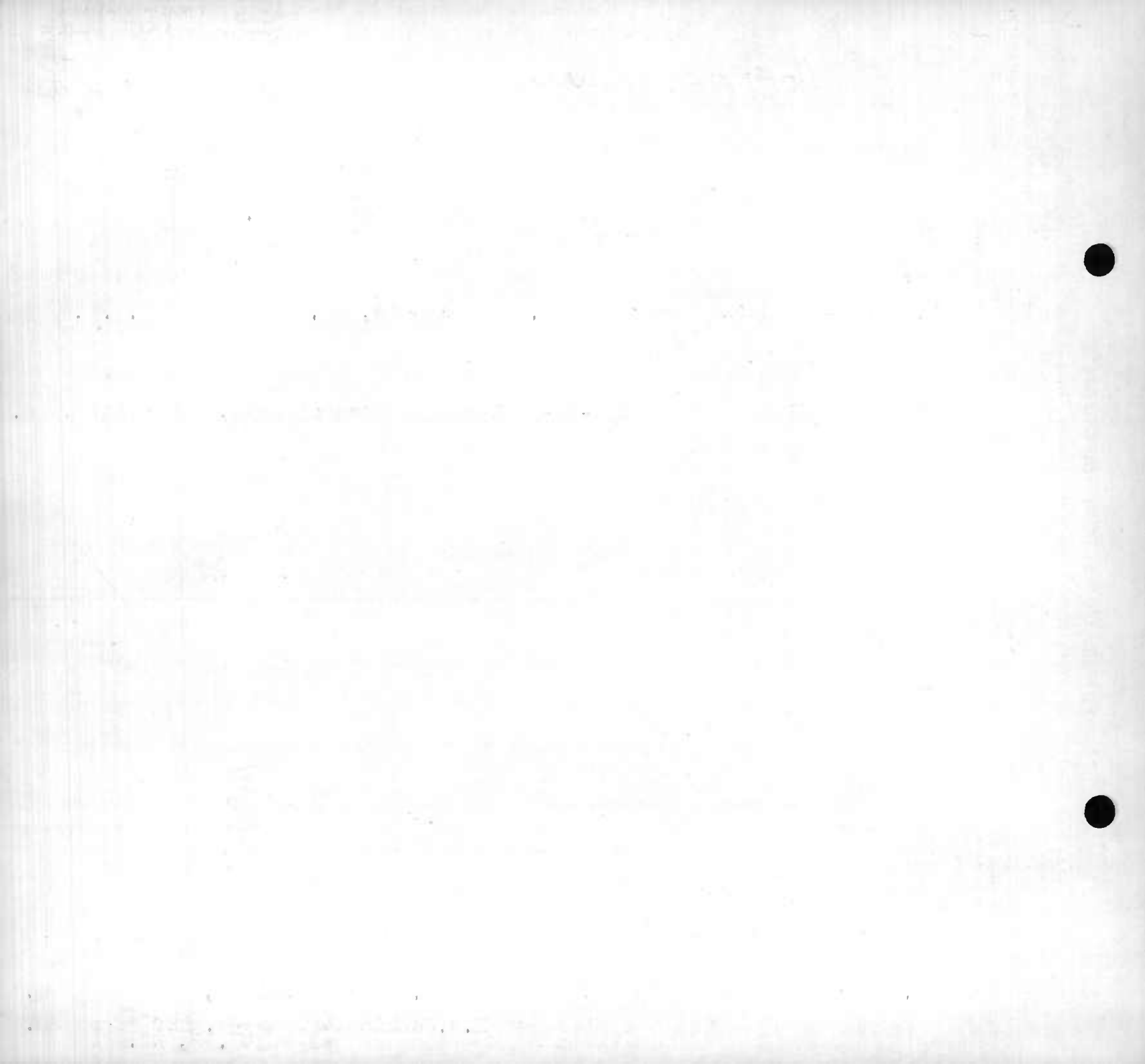


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9144 CERTIFICATE OF DEATH

REG. NO. 68- 9144

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HOFFMAN Charles		2. DATE AND HOUR OF DEATH September 6, '68 6:55 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital			C. CITY OR TOWN Baltimore 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3132 Guilford Ave.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1900	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Forester		10B. KIND OF BUSINESS OR INDUSTRY State of Pa.		11. BIRTHPLACE (State or foreign country) Shamokin, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frederick Hoffman			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 166-14-3841		17. INFORMANT Baggus Funeral Home, Belleville, Pa.	
18. 441.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HEMORRHAGE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANEURYSM OF AORTA, abdominal		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROSIS		(B) DUE TO, OR AS A CONSEQUENCE OF: EMPHYSEMA		3 years	
(C) 5 years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 451X II					
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-28-1968 to 9-6-1968 , that (I) (we) last saw the deceased alive on 9-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.S. Chalfant				23B. DATE SIGNED Sept 6, 68	
23C. PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT				23D. ADDRESS 6210 YORK ROAD, Baltimore MD 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 9/9/1968		24C. NAME OF CEMETERY or CREMATORY Allensville Presbyt.	
24D. LOCATION (City, town, or county) (State) Allensville, Pa.					
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
				ADDRESS 4905 York Rd. Balto. 12, Md.	



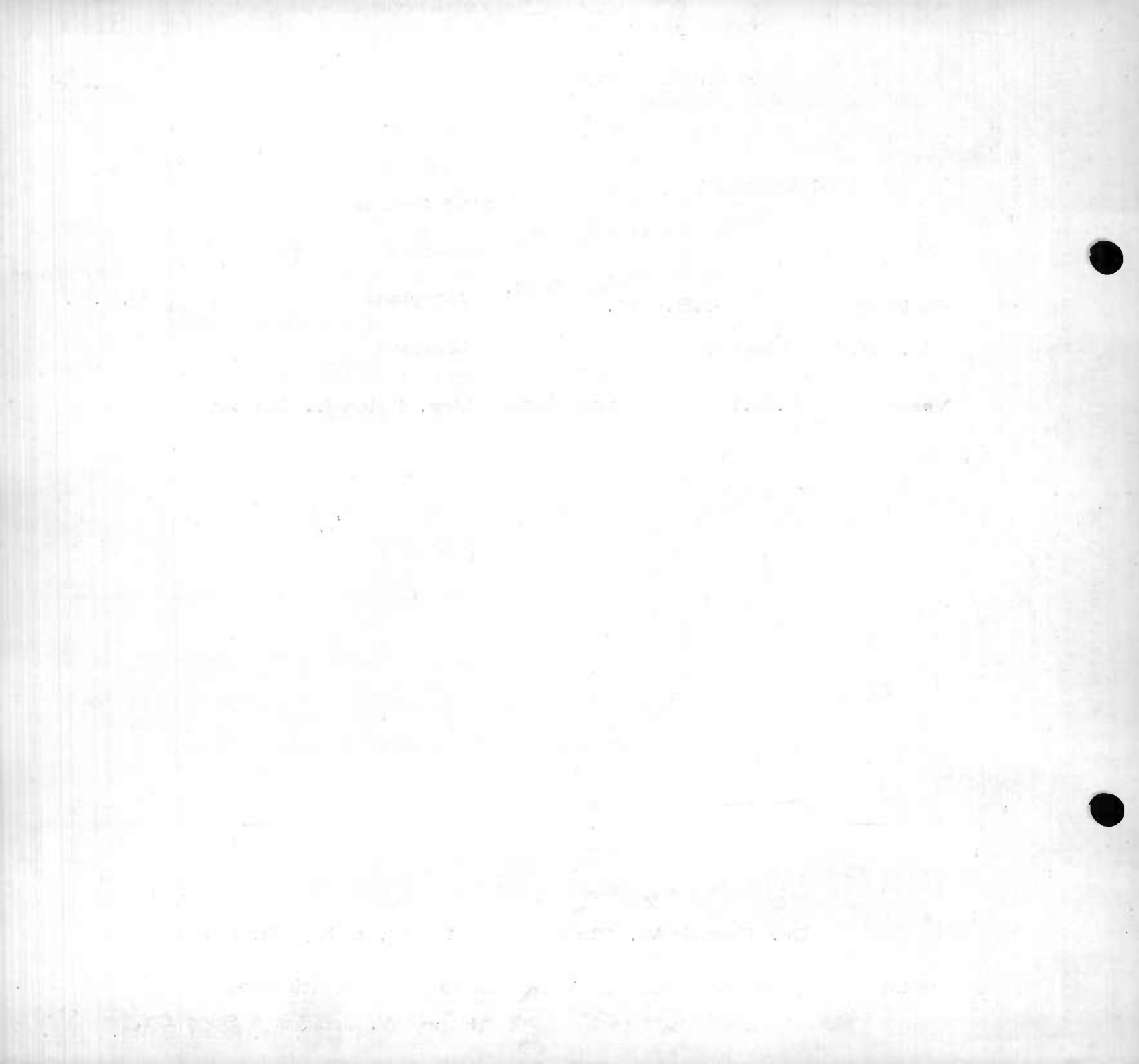
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9145 CERTIFICATE OF DEATH

REG. NO. **68- 9145**

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Edwin Charles Clayton		9-6-68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland	
				B. COUNTY	
00 3601 Greenway				C. CITY OR TOWN Baltimore	
				INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3601 Greenway					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 8-6-1894	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Navy Dept. U.S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME J. William Clayton				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 213-03-4123		17. INFORMANT Mrs. Helen E. Clayton	
				ADDRESS Same	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 153.0 I DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Carcinoma of ascending colon - extensive abdominal metastases (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 153.0 II					
19A. DATE OF OPERATION Oct 1961 July 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (This hospital) attended the deceased from 12/8/55 to 9/6/68 that (I) (we) last saw the deceased alive on 9/5/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Francis W. Gluck				23B. DATE SIGNED 9/6/68	
23C. PHYSICIAN'S NAME (Type) Dr. Francis W. Gluck				23D. ADDRESS 100 W. University Parkway	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9146 CERTIFICATE OF DEATH

REG. NO. 68- 9146

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Richard Thomas West		2. DATE AND HOUR OF DEATH Sept. 6, 1968 1: 30A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Park Drive			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE SC B. COUNTY V-37		
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7/19/48		9. AGE (In years last birthday) 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			11. BIRTHPLACE (State or foreign country) SC		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Boyd West			14. MOTHER'S MAIDEN NAME Mary Cooke		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 248-78-7291		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hodgkins' disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 201X I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 201X II					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I/this hospital) attended the deceased from July 29 19 68 to Sept. 6 19 68 , that (I/we) last saw the deceased alive on Sept. 6 19 68 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.					
23A. SIGNATURE M. Bellamy				23B. DATE SIGNED 9/6/68	
23C. PHYSICIAN'S NAME (Type) Murlyn D. Bellamy, Sr. Surgeon			23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/9/68		24C. NAME OF CEMETERY or CREMATORY GREEN LAWN, CEM. SPARTANBURG S.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR HENRY W. JENKINS + SONS, C.	
ADDRESS 4903 YORK RD. BALTIMORE 12					

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.					
1. NAME OF DECEASED (Type or Print) HENRY CHARLES FROEHLICH				2. DATE AND HOUR OF DEATH SEPTEMBER 5 '68 4⁰⁰ P.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 THE UNION MEMORIAL HOSPITAL 9-27-68				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 19-03									
				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
				E. STREET AND NUMBER 615 E. 37TH STREET									
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-01-1889		9. AGE (In years last birthday) 78		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL ENGINEER - KRSTEL CO.				10B. KIND OF BUSINESS OR INDUSTRY KRSTEL CO.				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? (AMERICA) U.S.A.			
13. FATHER'S NAME JOHN H. FROEHLICH				14. MOTHER'S MAIDEN NAME CATHERINE EVERHART									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-03-6458		17. INFORMANT MRS. MARY E. FROEHLICH (THE CHART) ADDRESS (SAME)							
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease Broncho pneumonia Pulm. edema				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Broncho pneumonia Pulm. edema (C) infection				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ABOUT 4 DAYS					
19A. DATE OF OPERATION 420.1 II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 4 1968 to SEPTEMBER 5 1968 , that (I) (we) last saw the deceased alive on SEPTEMBER 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE Chun Kee Ryu M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED SEPTEMBER 5, 1968					
23C. PHYSICIAN'S NAME (Type) CHUN KEE RYU M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9/9/1968		24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Park				24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968				25B. NAME OF REGISTRAR Robert E. Jenkins				25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore, Md.					

10-01-58 18

10-01-58 18

WHEELAND

CATHERINE EUGENIE

THE CHART

SEPTEMBER 2 1968

SEPTEMBER 4 1968

CHUN KEE KAY, M.D.

CLINICAL MEDICINE

M.D.

X

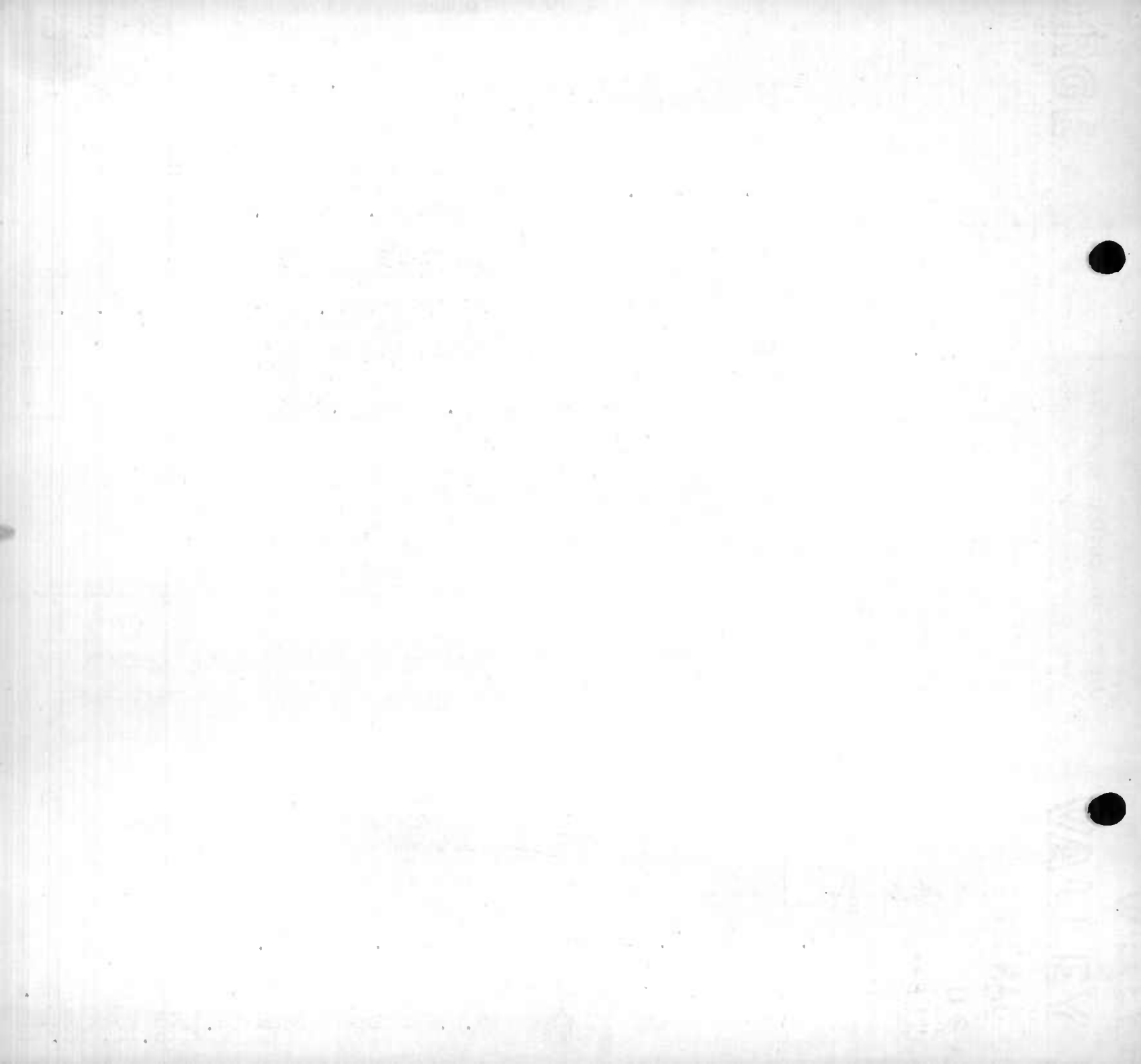
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9148 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9148

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Clara Charretton Judik		Sept. 7, 1968 1 42 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 3906 St. Paul St.				Maryland	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3906 St. Paul St.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/14/1885	9. AGE (In years lost birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME J. Henry Judik				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-4521		17. INFORMANT Mrs. Alfred C. dePierron	
				ADDRESS (Same)	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Due to, or as a consequence of: <i>myocardial infarction, acute</i> (B) <i>coronary artery dis. 5 yrs</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
MEDICAL CERTIFICATION 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1957 to 9/7 1958, that (I) (we) lost saw the deceased alive on July 19 1958 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William F. Renner</i>				23B. DATE SIGNED 9/9/58	
23C. PHYSICIAN'S NAME (Type) Dr. William F. Renner				23D. ADDRESS 3222 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/10/68		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore,		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9149
BIRTH NO.		68-9149 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
WAGEMANN, JOSEPHINE		9/8/68 6 ⁰⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		A. STATE Md B. COUNTY BALTIMORE Co		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 225 BURKE AVENUE				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/09	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE SUPERVISOR COLLEGE DORM		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW JERSEY
12. CITIZEN OF WHAT COUNTRY? AMERICAN				
13. FATHER'S NAME CARL VON HARTZ		14. MOTHER'S MAIDEN NAME ERNESTINE FREDERICK SCHNIOT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-34-5463		17. INFORMANT KURT WAGEMANN SEVEN VALLEYS, PA.
18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: LYMPHOSARCOMA (B) CARDIA ARREST DUE TO, OR AS A CONSEQUENCE OF: (C)		
200.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from 9/1 1968 to 9/8 1968, that (I) (we) last saw the deceased alive on 9/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 9/8/68		
23C. PHYSICIAN'S NAME (Type) LUIS LINTADO M.D.		23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 9-10-68	24C. NAME OF CEMETERY or CREMATORY Greenmount	24D. LOCATION (City, town, or county) Baltimore	(State) Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968	25B. NAME OF REGISTRAR [Signature]	25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.		

WASHINGTON, D.C.

HQ. BUREAU
BALTIMORE
555 BUREAU AVENUE

UNION MEMORIAL HOSPITAL

10/19/68

F W X

AMERICAN

NEW JERSEY

HOME

FREDERICK SCHMIDT

CARL VON HERTZ

LYMPHOSARCOMA

CARDIO ARREST

NO

10-11-68

10-11-68

W. J. ...

10/19/68

X

UNION MEMORIAL HOSPITAL

THIS LINTADO MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9150
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WINTER, EDNA A.		2. DATE AND HOUR OF DEATH 9/8/68 6³⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 12-02 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER BLACKSTONE APTS. CHARLES & 33RD STS.		
5. SEX F	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/89	9. AGE (In years lost birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE RETIRED SECRETARY ENG. CORP.		10B. KIND OF BUSINESS OR INDUSTRY CONSOLIDATED		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES W. WINTER			14. MOTHER'S MAIDEN NAME MARIE L O MATTHE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-05-2300		17. INFORMANT GEORGE G. RADCLIFFE ADDRESS 305 WEATHERBEE RD.	
18. 443X II DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC STANDSTILL DUE TO, OR AS A CONSEQUENCE OF: (B) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INDEFINITE
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 443X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from SEPTEMBER 5 19 68 to SEPTEMBER 8 19 68 , that the (we) last saw the deceased alive on SEPTEMBER 8 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) not view the body after death.					
23A. SIGNATURE Chun Kee Ryu M.D. DEGREE				23B. DATE SIGNED SEPTEMBER 8, 1968	
23C. PHYSICIAN'S NAME (Type) DR CHUN KEE RYU		23D. ADDRESS THE UNION MEMORIAL HOSPITAL		23E. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/1968		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Woodlawn, Balto. Co., Md.		24E. LOCATION (City, town, or county) (State) Balto. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

PHILIP MEMORIAL M.S.P. 1947

CHICKSTONE MTS CHICKSTONE

2/22/24 X

F WHITE

MAYLAND

CHARLES W. WINTER

NO

CHICKSTONE M.S.P. 1947

HYPERTENSIVE CARDIOVASCULAR DISEASE

NO

SEPTEMBER 2 1947

M.D.

Chun Kee Ryn

CHUN KEE RYN M.D.

THE PHILIP MEMORIAL M.S.P. 1947

X

SEPTEMBER 2 1947

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9151 CERTIFICATE OF DEATH

REG. NO. 68- 9151

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PETRAKOS, GEORGE STEVE		2. DATE AND HOUR OF DEATH 9/8/68 6:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE South Carolina B. COUNTY V-37		
FULL NAME OF HOSPITAL OR INSTITUTION USPHS Hospital 2X Wyman Park Dr. + 31st St.			C. CITY OR TOWN Greenville		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 21 Spring Forest Rd.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/29	9. AGE (In years last birthday) 38	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME Steven Petrakos			14. MOTHER'S MAIDEN NAME Rat Gonits		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1953-55		16. SOCIAL SECURITY NO. 247 569638		17. INFORMANT ADDRESS Admission Record (by patient)	
18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac + respiratory failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hodgkin's disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 201X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/24 1968 to 9/8 1968 , that (I) (we) last saw the deceased alive on 9/8 1968 and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JL Monroe, M.D.			23B. DATE SIGNED 9/8/68		23C. PHYSICIAN'S NAME (Type) Matthew Carr, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial			24B. DATE 9-8-68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Memorial Park
24D. LOCATION (City, town, or county) (State) Greenville S.C.			25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		
25B. NAME OF REGISTRAR Robert E. Jenkins			25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 1905 York Rd. Balto., Md.		

68 9/8

9/

✓ Hosp

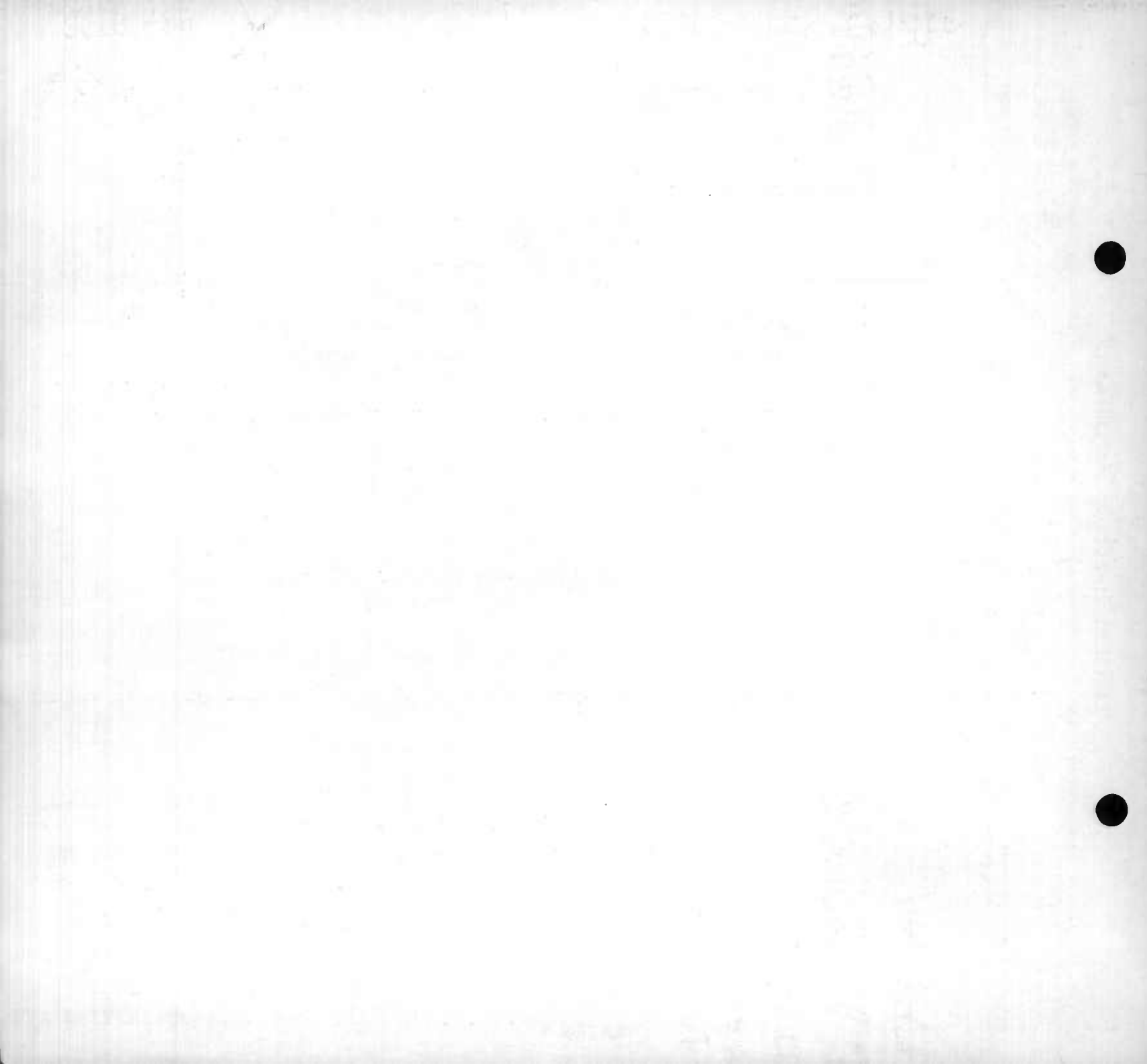
avilla

24

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

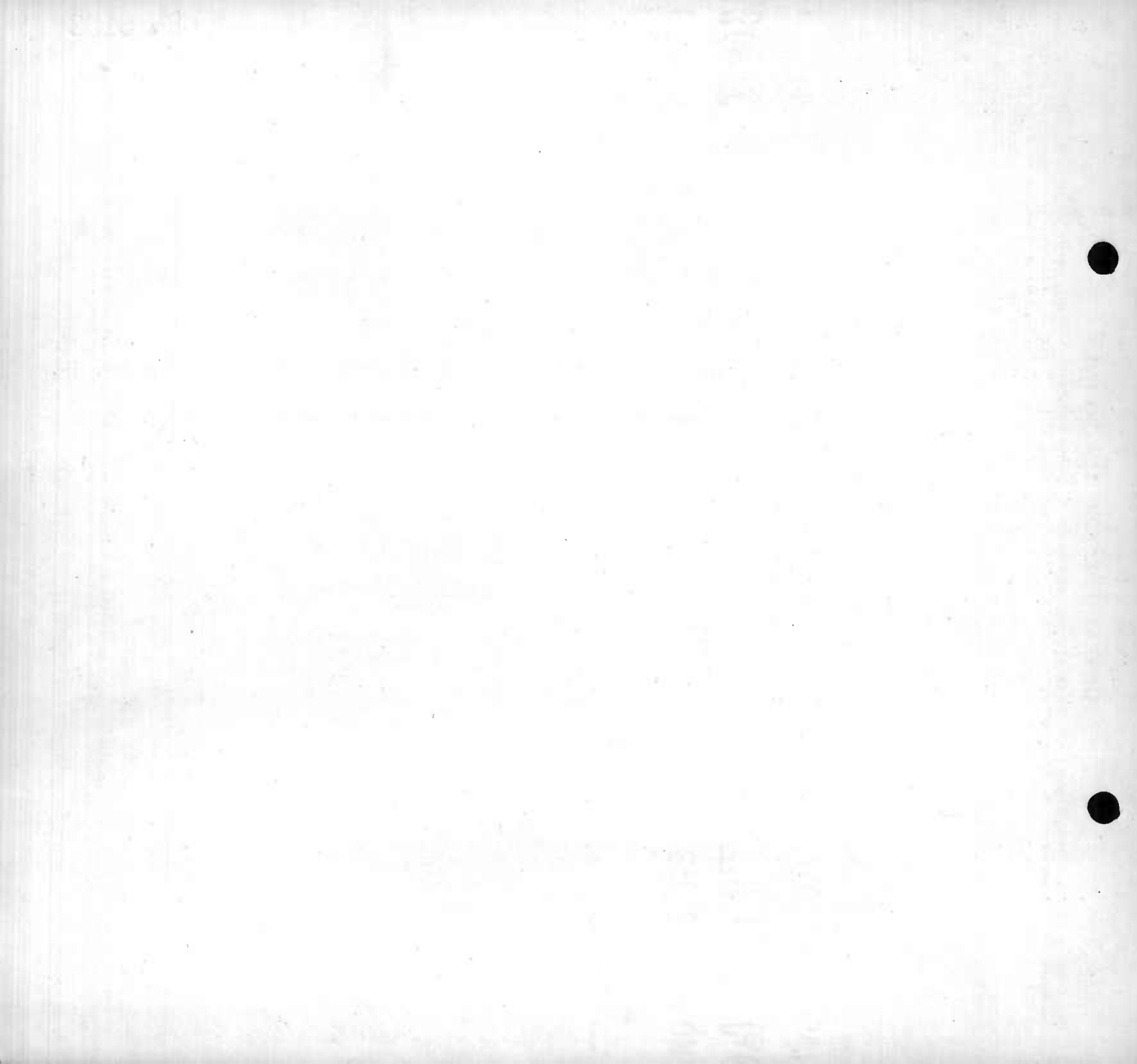
<div style="display: flex; justify-content: space-between;"> W-620 68-9152 BALTIMORE CITY HEALTH DEPT. </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. X 68-9152 </div>			
1. NAME OF DECEASED (Type or Print) MARIE WEIHRAUCH		2. DATE AND HOUR OF DEATH 9-8-68 3 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8055 PHILADELPHIA ROAD #21237	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-00
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 68
13. FATHER'S NAME James Luczkowski		14. MOTHER'S MAIDEN NAME Frances Groslop	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) -		16. SOCIAL SECURITY NO. None	17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD
18. 394.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGESTIVE HEART FAILURE RHEUMATIC HEART DISEASE WITH MITRAL VALVE INVOLVEMENT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 410X II			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 9/8 9/8 19 68 to 9/8 19 68 , that (B) (we) lost saw the deceased alive on 9/8 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Leonard Fengold M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 9/8/68
23C. PHYSICIAN'S NAME (Type) LEONARD FENGOLD		23D. ADDRESS 4940 EASTERN AVENUE, BALTIMORE, MD BALTIMORE CITY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/11/68	24C. NAME of CEMETERY or CREMATORY Western	24D. LOCATION (City, Town or County) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR John E. Jackson	
25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

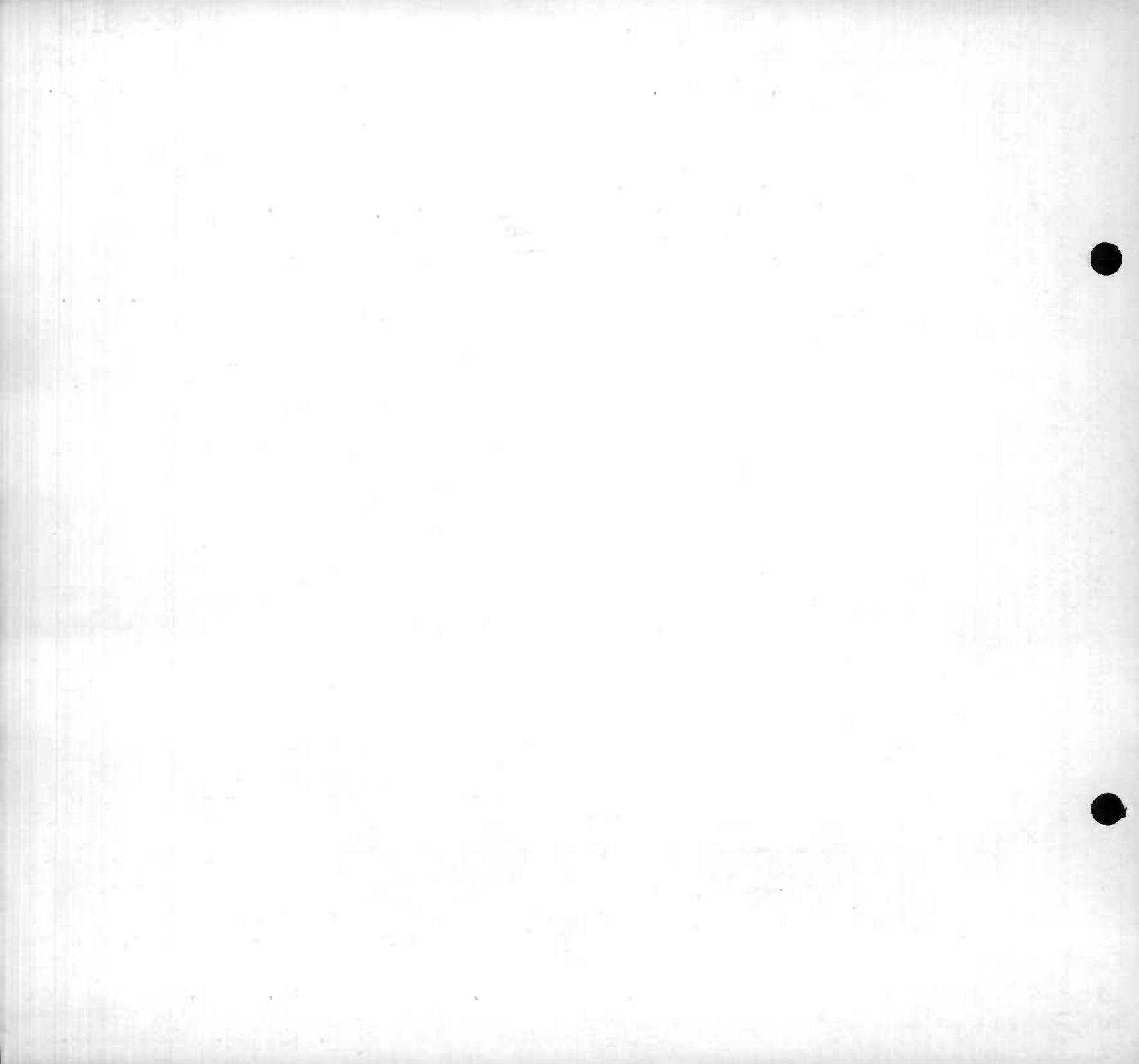
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9153	
BIRTH NO. 68- 9153		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CHARLES LIGHTY			2. DATE AND HOUR OF DEATH 9/8/68 5:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University of Md. Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 15-01		
FULL NAME OF HOSPITAL OR INSTITUTION University of Md. Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1555 Leslie Rd.		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/15/53	9. AGE (In years last birthday) 15	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Bishopville S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ed. Cooley			14. MOTHER'S MAIDEN NAME Annabelle Lighty		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Hosp. Chart
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subphrenic Abscess			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pharyngeal obstruction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Peptic Ulcer and Gastritis			(B) DUE TO, OR AS A CONSEQUENCE OF: Malnutrition		2 months
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 541.0 II			(C) DUE TO, OR AS A CONSEQUENCE OF: Peptic Ulcer and Gastritis		
19A. DATE OF OPERATION 7/26/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pharyngeal obstruction		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/11/68 to 9/8/68 , that (I) (we) last saw the deceased alive on 9/7/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 9/8/68		
23C. PHYSICIAN'S NAME (Type) [Signature]			23D. ADDRESS University of Md. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/68		24C. NAME OF CEMETERY or CREMATORY Oliver Hill	
24D. LOCATION Heartsville Rd		24E. LOCATION (City, town, or county) (State) Heartsville Rd			
25A. DATE RECEIVED BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR L. Harris Heartsville Rd	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO. 68- 9154

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 9155</u>	
BIRTH NO. <u>63</u>		68- 9155 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>FRANK T. ROBERT</u>			2. DATE AND HOUR OF DEATH <u>9/2/68</u> <u>1:10 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Maryland</u> <u>46</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/> E. STREET AND NUMBER <u>3306 Windsor Ave</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/94</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Ministry</u>		11. BIRTHPLACE (State or foreign country) <u>Sparta, GA.</u>	
13. FATHER'S NAME <u>Frank Roberts</u>			14. MOTHER'S MAIDEN NAME <u>Bettie Wynn</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>162-36-9915</u>		17. INFORMANT <u>From chart</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute myocardial infarct</u> <u>Bleeding due to Coumadin</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/20.1 II</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>9/2/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/28/68</u> to <u>9/2/68</u> , that (I) (we) last saw the deceased alive on <u>9/2/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>C. S. Ming</u>				23B. DATE SIGNED <u>9/2/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHEE SHWE MING</u>				23D. ADDRESS <u>Lutheran Hospital of Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/6/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arboretus Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>J. B. Johnson</u>	
25D. ADDRESS <u>1900 Eutaw Pl.</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9156 CERTIFICATE OF DEATH

REG. NO. 68- 9156

BIRTH NO.		1. NAME OF DECEASED (Type or Print) STANLEY J. MICHALSKI		2. DATE AND HOUR OF DEATH 9-6-68 3:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2-01	
FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2008 E. LOMBARD ST.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-87	9. AGE (In years last birth) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN		10B. KIND OF BUSINESS OR INDUSTRY STEAMSHIP TRADE		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOHN MICHALSKI		14. MOTHER'S MAIDEN NAME Mary Giuski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-6386		17. INFORMANT MELBA MICHALSKI E LOMBARD ST	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalized Carcinomatosis		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vallop				23B. DATE SIGNED 9/6/68	
23C. PHYSICIAN'S NAME (Type) VALLOP M.D.		23D. ADDRESS c/o BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-10-68		24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM.	
24D. LOCATION (City, town, or county) (State) DIUNDAIK BALTO MD.					
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jankura		25C. FUNERAL DIRECTOR John M. Weber-Spokane 401 S. CHESTER	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.				68- 9157			
1. NAME OF DECEASED (Type or Print) LORENZO MASON								2. DATE AND HOUR OF DEATH September 7th 11:05 M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205								C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1018 E. MONUMENT STREET							
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-10		9. AGE (In years lost birthday) 57		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer								10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Nansemond Co., Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.								13. FATHER'S NAME JOHN MASON							
14. MOTHER'S MAIDEN NAME ANNIE Savage								15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)							
16. SOCIAL SECURITY NO. 220-03-6362								17. INFORMANT Mr. Clark Blowe							
ADDRESS Suffolk, Virginia								18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) ASCLVD DUE TO, OR AS A CONSEQUENCE OF: (C) 10 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr							
19A. DATE OF OPERATION None								19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) None							
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)								21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								21F. HOW DID INJURY OCCUR?							
22. I certify that (it) (this hospital) attended the deceased from 7 1940 to 917 1968 , that (it) (we) last saw the deceased alive on 6128 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE Richard W. Light MD OEGREE															
23B. DATE SIGNED 9/7/68															
23C. PHYSICIAN'S NAME (Type) Richard W. Light M.D. OEGREE															
23D. ADDRESS Johns Hopkins Hospital Balt. Md															
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-11-68				24C. NAME OF CEMETERY or CREMATORY Healing Chapel Cemetery				24D. LOCATION (City, town, or county) (State) Nansemond Co. Va			
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968				25B. NAME OF REGISTRAR Robert E. Johnson				25C. FUNERAL DIRECTOR MORTON & DYETT F.H.				ADDRESS 1701 Laurens St.			

221VAC

1962-1963

Wassenaar Co. N.Y.

Heating & Air Conditioning

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9158 CERTIFICATE OF DEATH

REG. NO. 68- 9158

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LAWRENCE HOLMES		2. DATE AND HOUR OF DEATH SEPT 5, 1968 6¹⁶ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP of BALTO 42		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3627 Wabash Ave		5. SEX M 6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 9/8/05		9. AGE (In years last birthday) 62		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel Holmes		14. MOTHER'S MAIDEN NAME Hollie Holmes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-16-3507		17. INFORMANT Mrs. Ruth Booker ADDRESS 3627 Wabash	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 7/10/0 I ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HTAS CVD		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PERFORATED GASTRIC ULCER (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN IN PAST 5-7 HRS. UNKNOWN 2-3 days	
19A. DATE OF OPERATION 19/3/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED GASTRIC ULCER		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> N/A		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Stuart H. Spielman DEGREE				23B. DATE SIGNED 9/5/68	
23C. PHYSICIAN'S NAME (Type) STUART H. SPIELMAN DEGREE		23D. ADDRESS SINAI HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Morton E. Dyett F.H.	
25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens					

For the
...
...
...

Baltimore, Maryland
Hotel, Johns

Daniel, Johns

...

Daniel, Johns
...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) BRADY ERVIN			2. DATE AND HOUR OF DEATH 9/4/68 12:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1208 HARWOOD AVE.		
5. SEX M	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-40	9. AGE (In years lost birthday) 28	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Bessemer City, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Conrad ERVIN			14. MOTHER'S MAIDEN NAME Lillie Mae Henderson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. -	17. INFORMANT Jesse ERVIN From Aunt. 3036 E. Federal		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 292.6 II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Branchospasm + anemia Sickle cell syndrome.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Renal disease					
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/2/68 to 9/4/68 , that (I) (we) last saw the deceased alive on 9/4/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David KHOO M.D.			23B. DATE SIGNED 9/4/68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) DAVID KHOO			23D. ADDRESS LUTHERAN HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-9-68		24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Morton E. Dyett F.H. 1701 LAURENS ST.	

x

1

December 27, 1900

Little Rock, Ark.

Dear Sir:

Enclosed

Very truly yours,

General E. A. Smith

No.

Enclosed 2-10-1000 General E. A. Smith

Trusted to Pay to M. H. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9160 CERTIFICATE OF DEATH

REG. NO.

68- 9160

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary Cornish		9-6-68 9:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1105 E. Fayette Street				B. COUNTY Baltimore	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 422 Mosher Street	
5. SEX F	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-11-1891	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Samuel Wilkins			
14. MOTHER'S MAIDEN NAME Eustace Tilden		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Virginia 3034 Winsor Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Cerebro Vasc. Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension			
		(B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the deceased) attended the deceased from Aug. 13, 1968 to Sept 6, 1968, that (I) (We) last saw the deceased alive on 9-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED 9-6-68	
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook MD				23D. ADDRESS 2431 Maryland Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/10/68		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION A. A. County, Md		(City, town or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Joseph B. Locks	
				ADDRESS 1304 N. Central Ave	

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

68- 9161

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9161

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ANDRE K. THOMAS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

September 7, 1968

8:24 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 7, 1968

8:24 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX
Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1-25-59

10. AGE (In years
last birthday) 9If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

555 Radnor Avenue 554 RADNOR AVE

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

CHARLES Thomas

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NONE

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

JOYCE Pulley

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Charles Thomas 554 Radnor Ave

19.

E814.1

CAUSE OF DEATH

Injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E812.4 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Coldspring Lane - E. of Alhambra

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) Sept. 7, 1968 8:05 P. M.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by car while operating
bicycle.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 8, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

9/11/68

24C. NAME OF CEMETERY or CREMATORY

Antietam Mtn. PK.

24D. LOCATION (City, town, or county)

Antietam - Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 9 1968

25B. NAME OF REGISTRAR

Robert E. [unclear]

25C. FUNERAL DIRECTOR

Joseph B. Rock 13042 - Central Ave

ADDRESS

10-2-34

RECEIVED

1-2-34

NOV

1934

NOV

Charles Thomas
Joyce P. Thomas
Charles Thomas

WALKER & BROTHERS

RECEIVED

Charles Thomas

Joyce P. Thomas

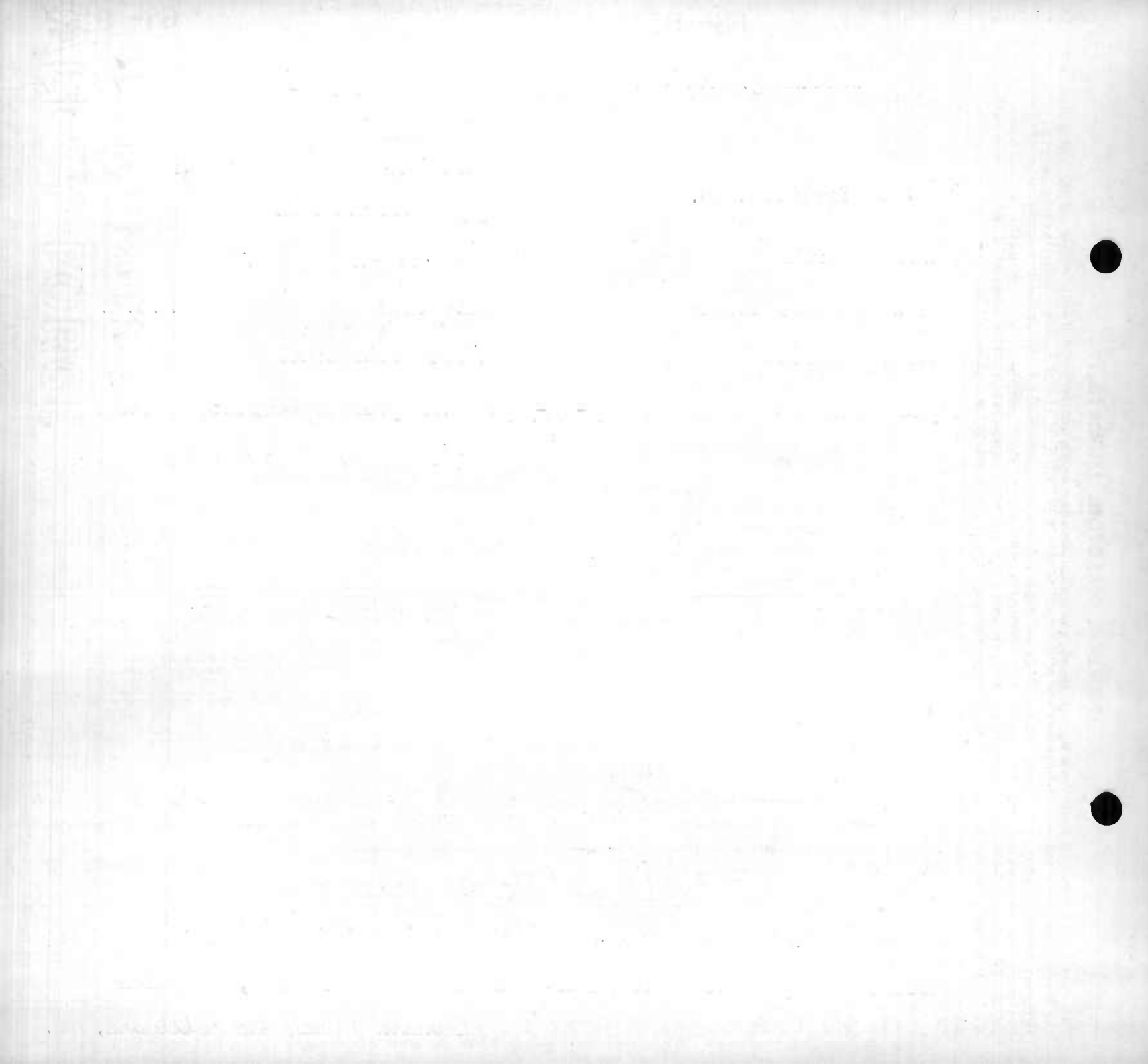
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9162 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9162

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William E. Wielert</i>		2. DATE AND HOUR OF DEATH <i>9/7/68</i> <i>11³⁰ A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 Johns Hopkins Hosp.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <i>26-01</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>5471 Whitwood Rd</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 4, 1895</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal Worker</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Philip Wielert</i>			14. MOTHER'S MAIDEN NAME <i>Philomenia Bruns</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i> <i>WW 1</i>		16. SOCIAL SECURITY NO. <i>215-03-7150</i>	17. INFORMANT <i>Mrs Ella May Wielert</i>		ADDRESS <i>Same</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>4/20/1 II</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Asymptomatic bronchitis & emphysema coronary atherosclerosis - Angina ACVD</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>3 yrs.</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <i>March 30</i> 19 <i>68</i> to <i>Sept 7</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Sept 7</i> 19 <i>68</i> and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph F. Li Pira MD</i>			23B. DATE SIGNED <i>Sept. 7, 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>Joseph F. Li Pira MD</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>9/10/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Pk</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1968</i>		
25B. NAME OF REGISTRAR <i>Robert E. Fisher, MA</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i>		



52-07-04 1B1

R-540

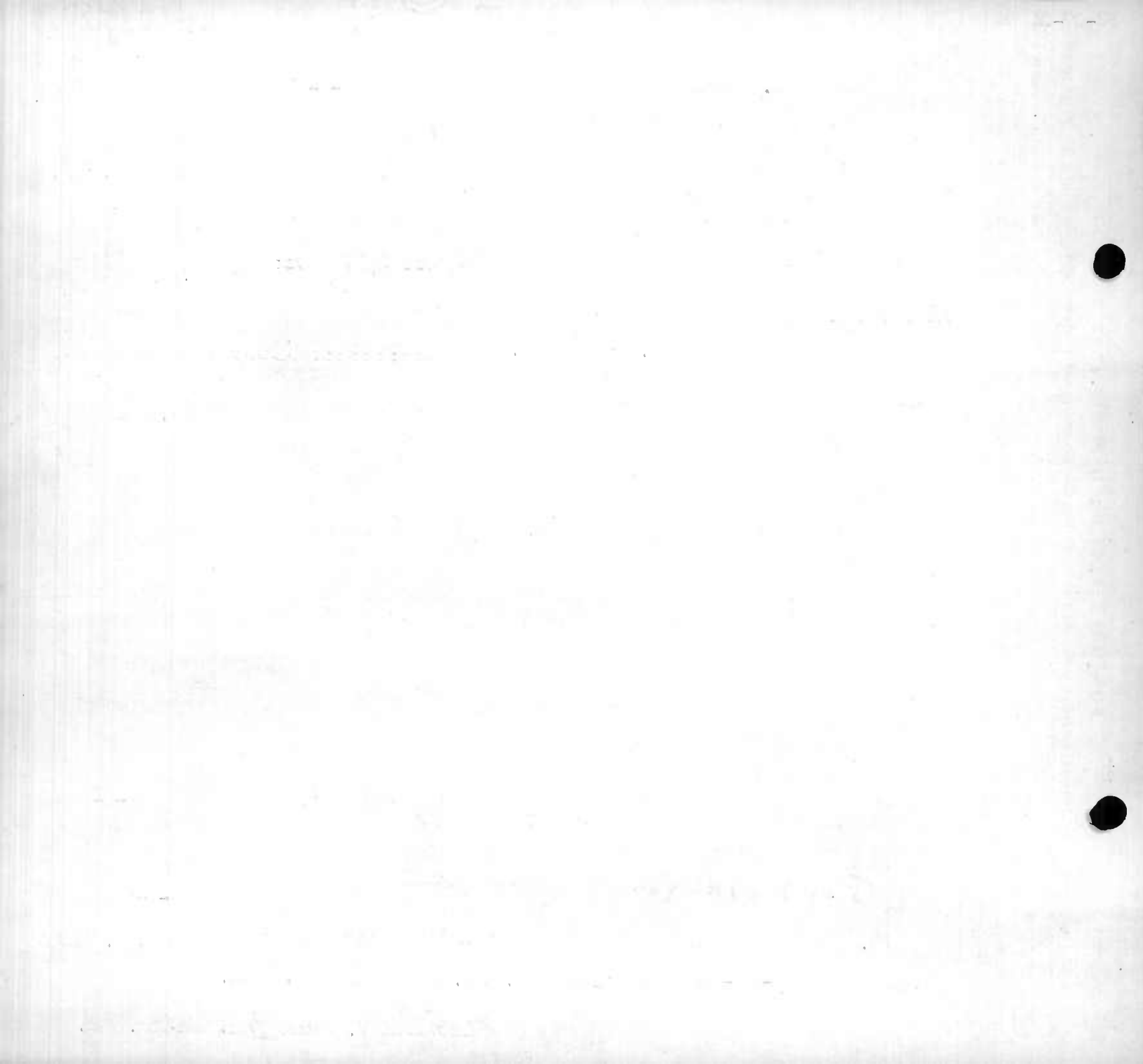
BALTIMORE CITY HEALTH DEPARTMENT
68- 9163 CERTIFICATE OF DEATH

REG. NO. 68- 9163

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Ramona M. Rommal		2. DATE AND HOUR OF DEATH 9-7-68 2 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 901 WOODBOURNE AVENUE, #21212	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-22 1921	9. AGE (In years lost birthday) 45 47	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME RUSSELL R. Hagan Sr.		14. MOTHER'S MAIDEN NAME Bernardine Thompson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Anaplastic Carcinoma OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Phlebotrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One day 13 months			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-13 19 68 to 9-7- 19 68 , that (I) (we) last saw the deceased alive on Sept. 7 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Qais Ali Awuati				23B. DATE SIGNED 9-7-68	
23C. PHYSICIAN'S NAME (Type) DR. QAIS ALI AWUATI		23D. ADDRESS BCH-4940 EASTERN AVENUE, BALTIMORE, MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-10-68		24C. NAME of CEMETERY or CREMATORY Moreland Mem. Pk.	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



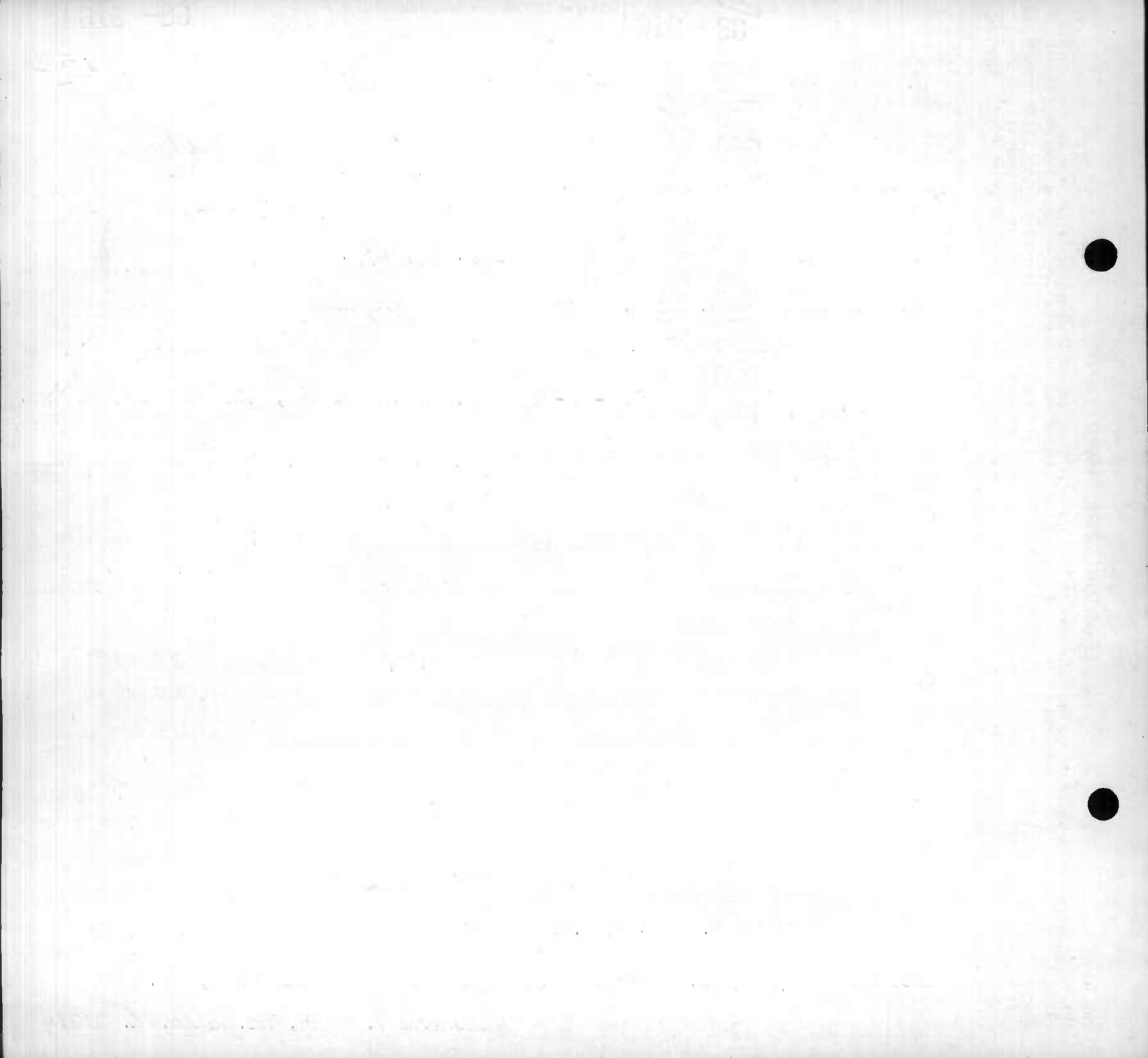
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9164 CERTIFICATE OF DEATH

REG. NO. 68- 9164

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Albert Batzer</i>		2. DATE AND HOUR OF DEATH <i>9/7/68</i> <i>10¹⁵ A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>House in Pines Belair Road. 90</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>2706 Evergreen Avenue</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 14, 1877.</i>		9. AGE (In years last birthday) <i>91</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Credit Mgr. Dept. Store</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John Albert Batzer</i>			14. MOTHER'S MAIDEN NAME <i>Anna Bokel</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-07-0833</i>		17. INFORMANT ADDRESS <i>Mr. Howard Kreis, 3318 Westerwald Ave.</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Generalized arteriosclerosis with myocardial degeneration</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>year</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Severely</i>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 1963</i> to <i>September 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 4, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William L. Fearing, M.D.</i>				23B. DATE SIGNED <i>9-9-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>William L. Fearing, M.D.</i>				23D. ADDRESS <i>3025 Belair Rd, Balt, Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/10/68.</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

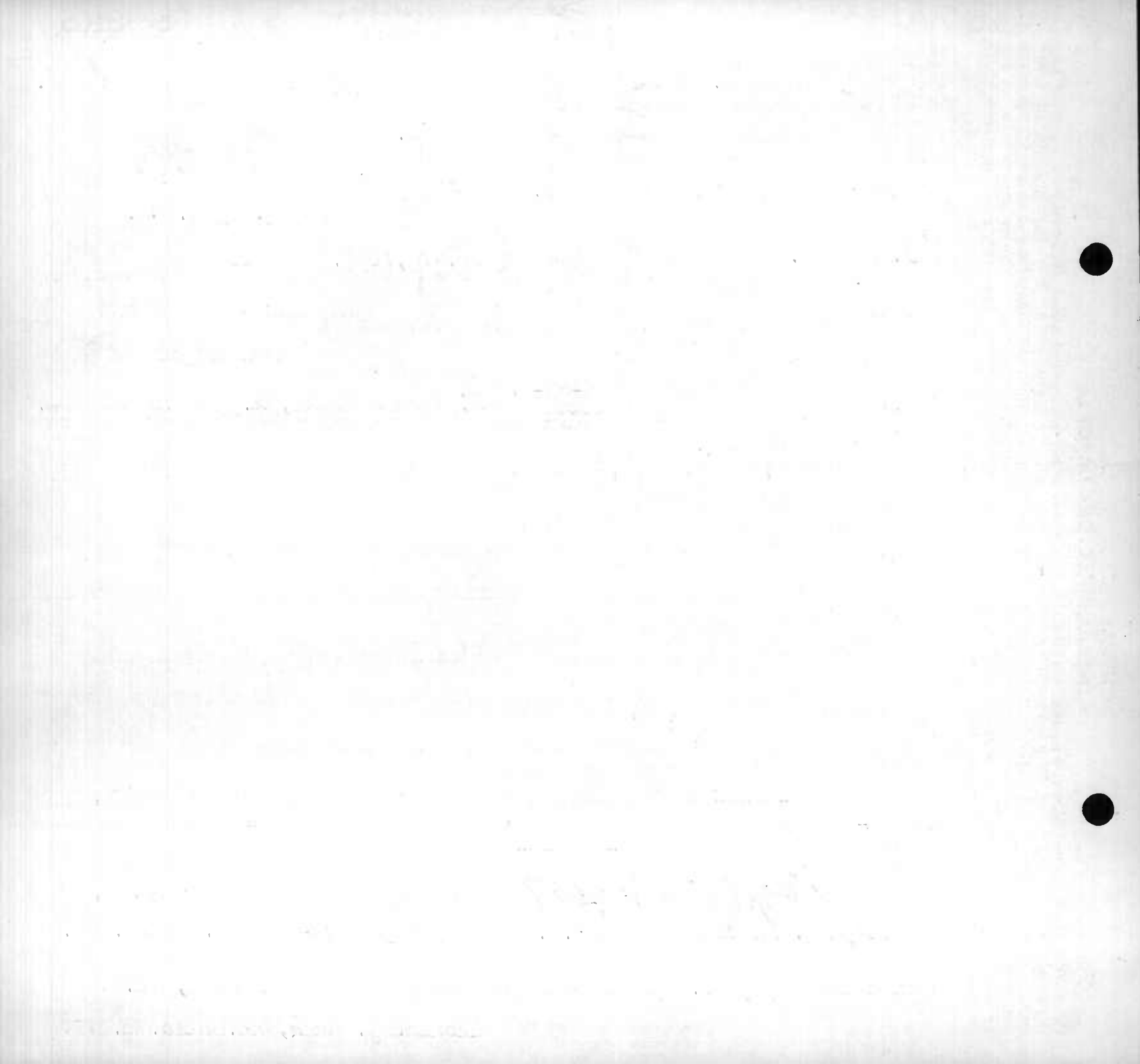
68- 9165 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9165

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Gertrude H. Moore</i>		2. DATE AND HOUR OF DEATH <i>9/7/68</i> <i>2:00 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 House in the Pines Belair Rd.</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>604 E. 35th. St.</i>		
5. SEX <i>F.</i>	6. RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 13, 1879.</i>	9. AGE (In years lost birthday) <i>88</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Heinrich & Heine</i>			14. MOTHER'S MAIDEN NAME <i>Louisa Calvert</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>256-11135</i>		17. INFORMANT ADDRESS <i>Mr. Turner Moore, Jr. 3310 Taylor Ave.</i>	
18. <i>4124 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic cardiovascular disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>4221 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>September 19 63</i> to <i>September 7, 19 68</i> , that (I) (we) last saw the deceased alive on <i>August 28, 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i>			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Sept. 9, 1968</i>
23C. PHYSICIAN'S NAME (Type) <i>Lloyd E. Saylor</i>			23D. ADDRESS <i>3902 Greenmount Ave. Balto. Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>9/9/68.</i>		24C. NAME of CEMETERY or CREMATORY <i>Greenmount Crematory</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Saylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9166 CERTIFICATE OF DEATH

REG. NO. 68- 9166

BIRTH NO.		1. NAME OF DECEASED (Type or Print) COCKEY, MERCEDES M.		2. DATE AND HOUR OF DEATH SEPT. 7 - 1968 11:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3020 Oakcrest Avenue	
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/1890	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Internal Revenue		10B. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME Joseph D. Cockey		
14. MOTHER'S MAIDEN NAME Anna Hines			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 214-40-1199			17. INFORMANT F.J. Walzog Jr. same		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Acute Coronary Occlusion Atherosclerotic Cardiovascular Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 9-7-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 9-7-1968 19 to 9-7- 19 68 , that (H) (we) last saw the deceased alive on 9-7-1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Notarangelo M.D. DEGREE				23B. DATE SIGNED 9-8-1968	
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO MD. DEGREE				23D. ADDRESS MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/68		24C. NAME OF CEMETERY or CREMATORY Sater Baptist Church Cem. Brooklandville, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto Md.			

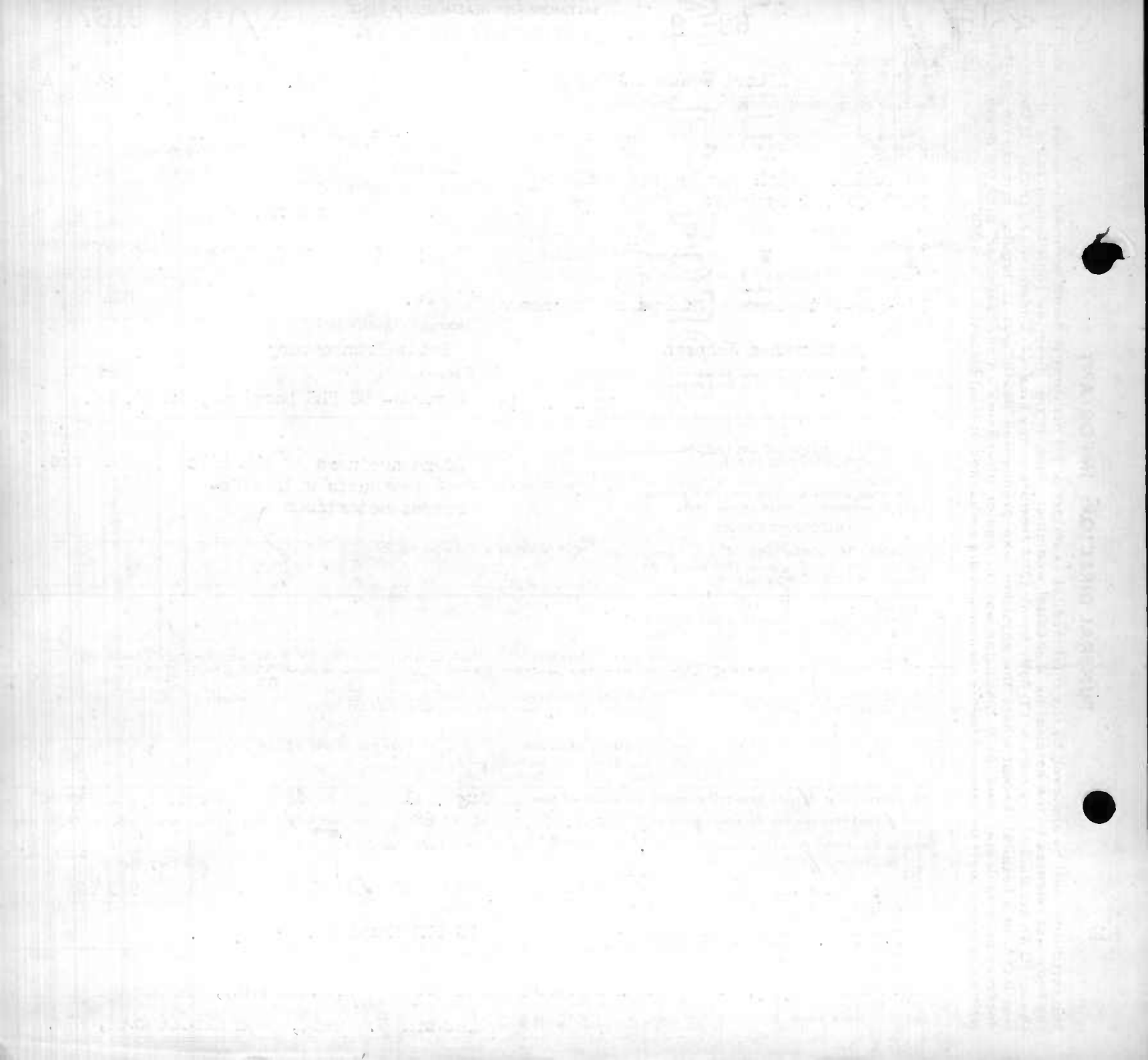
68- 9167 CERTIFICATE OF DEATH

REG. NO. 68- 9167

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Albert Francis Johnson		Sept. 5, 1968 9:49 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive				A. STATE Delaware B. COUNTY V-07	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Newark D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER Briggs Mobile Home, RD #1	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/07	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman-Watertender		10B. KIND OF BUSINESS OR INDUSTRY Corps of Engineers		11. BIRTHPLACE (State or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Remembrance Johnson			14. MOTHER'S MAIDEN NAME Leota Frankenburg		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 221-14-8968		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF THE BILE DUCTS WITH WIDE-SPREAD METASTASES					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
156.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Aug. 11 19 68 to Sept. 5 19 68, that (1) (we) last saw the deceased alive on Sept. 5 19 68 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
23A. SIGNATURE Henry S. Crist, M.D.				23B. DATE SIGNED 9/5/68	
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/68		24C. NAME OF CEMETERY or CREMATORY Silverbrook Cemetery	
				24D. LOCATION (City, town, or county) (State) Wilmington, Delaware	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc Baltimore, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9168

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Frank Morisi</i>		2. DATE AND HOUR OF DEATH <i>Sept. 6, 1968</i> 4 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 1159 Sherwood Ave.</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <i>1159 Sherwood Ave.</i>		
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-23-1893</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Tailor</i>			11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Paul Morisi</i>			14. MOTHER'S M maiden NAME <i>Rose Poggioli</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218105187</i>	17. INFORMANT <i>Paul Morisi</i>		ADDRESS <i>same</i>
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Coronary artery disease.</i> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>G. Lee Russo</i>			23B. DATE SIGNED <i>9/6/68</i>		23C. PHYSICIAN'S NAME (Type) <i>G. Lee Russo</i>
23D. ADDRESS <i>MD 1010 St. Paul St., Balto. d.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE	24C. NAME OF CEMETERY or CREMATORY <i>Mt. Rose Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Bx York, Penna.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Tully</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc Baltimore, Md.</i>	

10-10-10

10-10-10

10-10-10

10-10-10

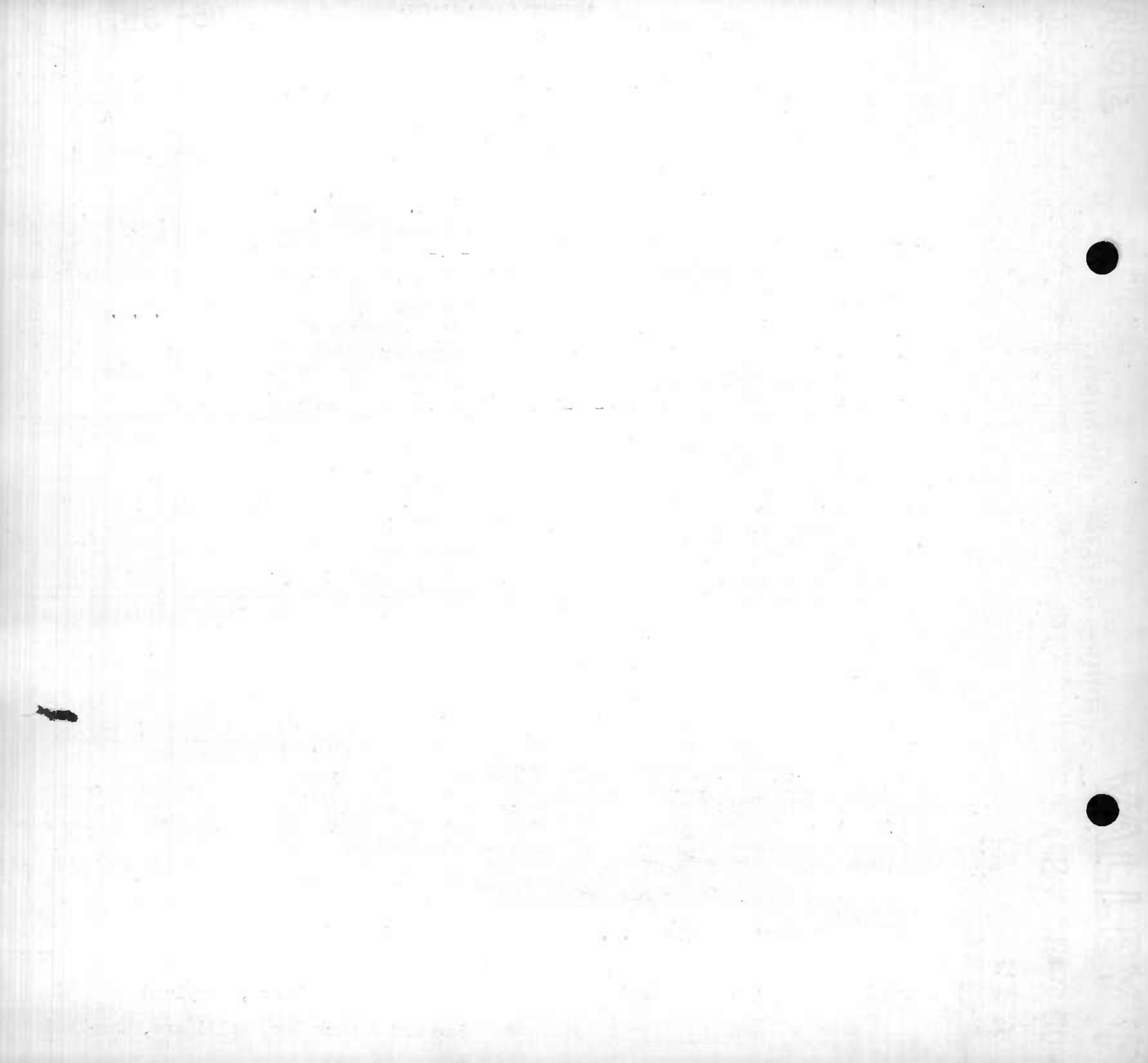
10-10-10

10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9169	
BIRTH NO.		68- 9169		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
THELMA L MANTLER		9/5/68		8 25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL		MARYLAND			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		Yes <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1721 E. 35TH St.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-25-05	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Samuel Lovett		Carrie Caroline Hartel		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-09-3640		Mr Gordon T Mantler Same	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		RESPIRATORY ARREST			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CEREBRAL METASTASES			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
		CARCINOMA OF BREAST			
170X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NONE				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8-17 19 68 to 9-5 19 68, that (I) (we) last saw the deceased alive on 9-5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Vernmont Tolo M.D.		9-5-68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Vernmont Tolo M.D.		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/9/68		Druid Ridge	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 9 1968		Robert E. Fashy		Leonard J Ruck Inc Baltimore, Maryland	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9170

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edith E. O'Donovan

2. DATE AND HOUR OF DEATH

Sept 7 68

11:45 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

91 Montebello State Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Ind

C. CITY OR TOWN

Balto 212 18

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3634 Ellerslie Ave

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8/15/1906

9. AGE (In years lost birthday)

62 72

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Teacher (Housewife)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

US (Penn.)

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

Wm. R. Enlow

14. MOTHER'S MAIDEN NAME

Pearl Babant

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unk.

17. INFORMANT

Edith Shanley

ADDRESS

729 Argonne Dr Balto 21218

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Myocardial Infarction

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 hr

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Right Cerebral Thrombosis

5 months

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1 1968 to Sept 7 1968, that (I) (we) last saw the deceased alive on July 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hea Rhen MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Sept 7 '68

23C. PHYSICIAN'S NAME (Type)

Hea Rhen

23D. ADDRESS

Montebello Hosp. Balto 21218

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/10/68

24C. NAME OF CEMETERY or CREMATORY

Moreland Mem. Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE RECEIVED BY HEALTH DEPT.

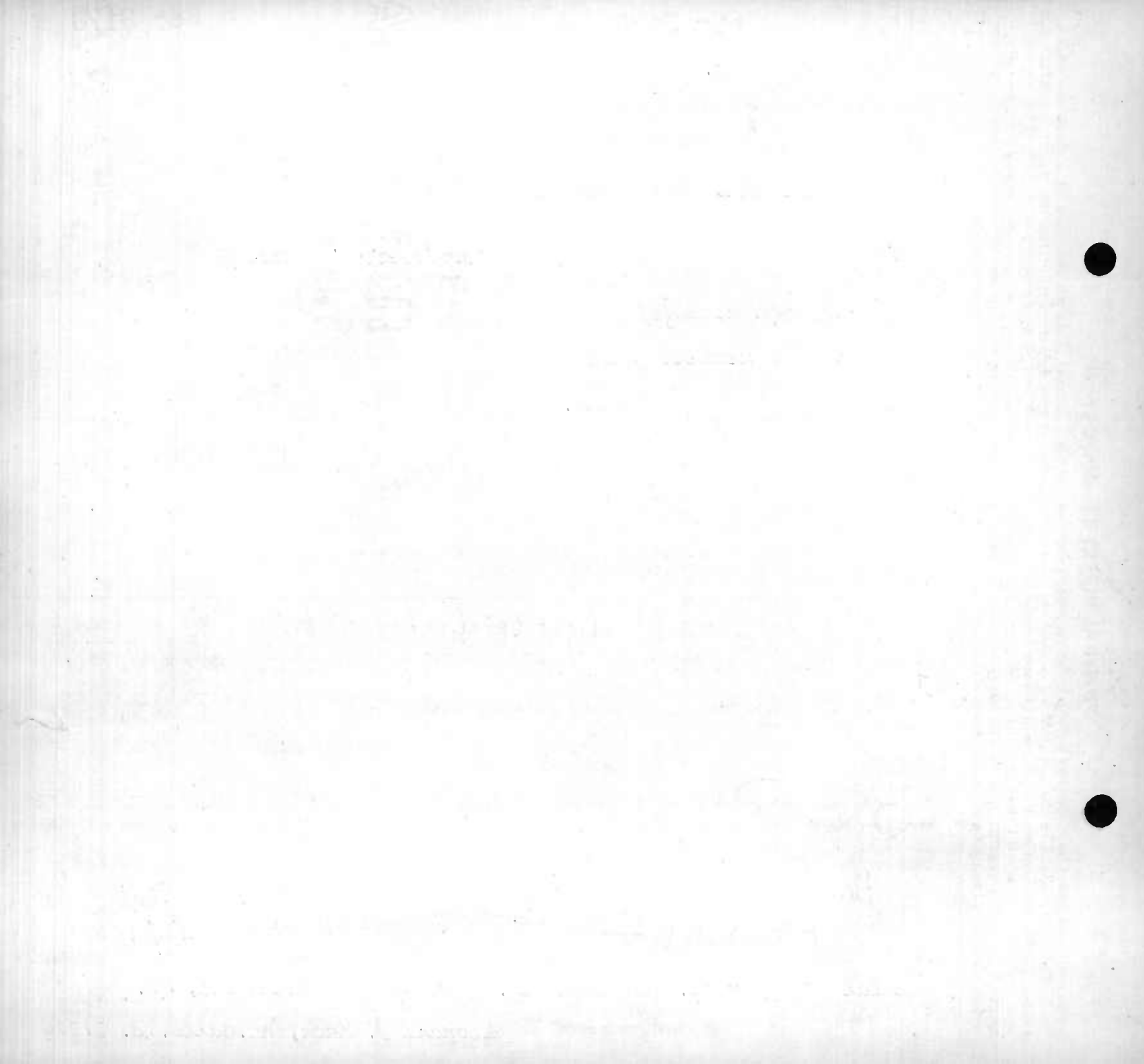
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9171

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Nellie C. Black

2. DATE AND HOUR OF DEATH

Sept. 6, 1968

4:15 am.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1700 Meridene Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1700 Meridene Drive

5. SEX

female

6. RACE

white

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Dec. 26, 1881

9. AGE (In years lost birthday)

86

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

?

Clark

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unk.

17. INFORMANT

Nancy Beck, Norfolk, Va.

ADDRESS

18.

2009 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF:

(B) cerebrovascular arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF:

(C) diabetes, hypertrophic arthritis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 hr

several yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

hypertrophic arthritis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April, 1948 to September 6, 1968, that (I) (we) last saw the deceased alive on 8-14-68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. Ellsworth Cook

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

9-6-68

23C. PHYSICIAN'S NAME (Type)

E. Ellsworth Cook

23D. ADDRESS

MD.

2431 Maryland Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/9/68

24C. NAME of CEMETERY or CREMATORY

Methodist Cemetery

24D. LOCATION

(City, town, or county)

Charlestown, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 9 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc Baltimore, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9172
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ETTA M. KRAUSE		2. DATE AND HOUR OF DEATH SEPTEMBER 7 1968 3⁵⁰ PM.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 44 THE UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? 27801
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 5013 EDGAR TERR		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-1893	9. AGE (In years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? AMERICA		13. FATHER'S NAME ROBERT HALL SMITH		
14. MOTHER'S MAIDEN NAME WILHELMINIA MOMMEN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-44-9067		17. INFORMANT THE CHART Miss Audrey M. Krause		
18. CAUSE OF DEATH Pulmonary embolism (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Thrombophlebitis right leg		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 89		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 463X II				
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from AUGUST 27, 1968 to SEPTEMBER 7, 1968 , that (I) (we) last saw the deceased alive on SEPTEMBER 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Chun Kee Ryu M.D.		23B. DATE SIGNED SEPTEMBER 7, 68		23C. PHYSICIAN'S NAME (Type) CHUN KEE RYU M.D.
23D. ADDRESS THE UNION MEMORIAL HOSPITAL		23E. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/11/68	24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 8 1968	25B. NAME OF REGISTRAR Robert C. Jackson	25C. FUNERAL DIRECTOR ADDRESS 21214		

ETNA M. KENNEDY

SEP 11 1953

LABORATORY

X

BALANCE

THE UNION MEMORIAL HOSPITAL

5015 EDGAR TESS

X

FEMALE WHITE

4-11-1953

AMERICA

MICHAEL M. MOWAT

ROBERT WALL SMITH

THE CHART

24

SEPTEMBER 11 1953 AUGUST 20 1953

THE UNION MEMORIAL HOSPITAL

CHAS KEE RAY
W.D.
CHAS KEE RAY
W.D.

1
B-622

68- 9173 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9173

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE M. BURGESS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> September 7, 1968 1:20 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 7, 1968 1:20 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. CITY OR TOWN Baltimore
9. DATE OF BIRTH Dec. 1921	10. AGE (In years last birthday) 39	11. BIRTHPLACE (State or foreign country) D. C. Linton	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arthur Burgess	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		15. MOTHER'S MAIDEN NAME Irene Young	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean		17. SOCIAL SECURITY NO.	
18. INFORMANT Natie Martin		ADDRESS 2800 Southern Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of Chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) North and Calvert - SE Corner		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
22D. TIME OF INJURY (APPROX.) Sept. 7, 1968 1:00 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Sept 9 / 68	
24C. NAME OF CEMETERY or CREMATORY Bethel Mt. Cem.		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave.	
25A. DATE REC'D BY HEALTH DEPT. SEP 8 1968		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Frank T. [Signature]		ADDRESS 1129 N. [Signature]	

Mr. W. C. Butler
Creek House
Lyon, Kansas

Arthur Burpee
Bureau of Forestry
Washington, D. C.

April 11/12

James S. Gifford, Esq.
General, Chickasaw County, Miss.

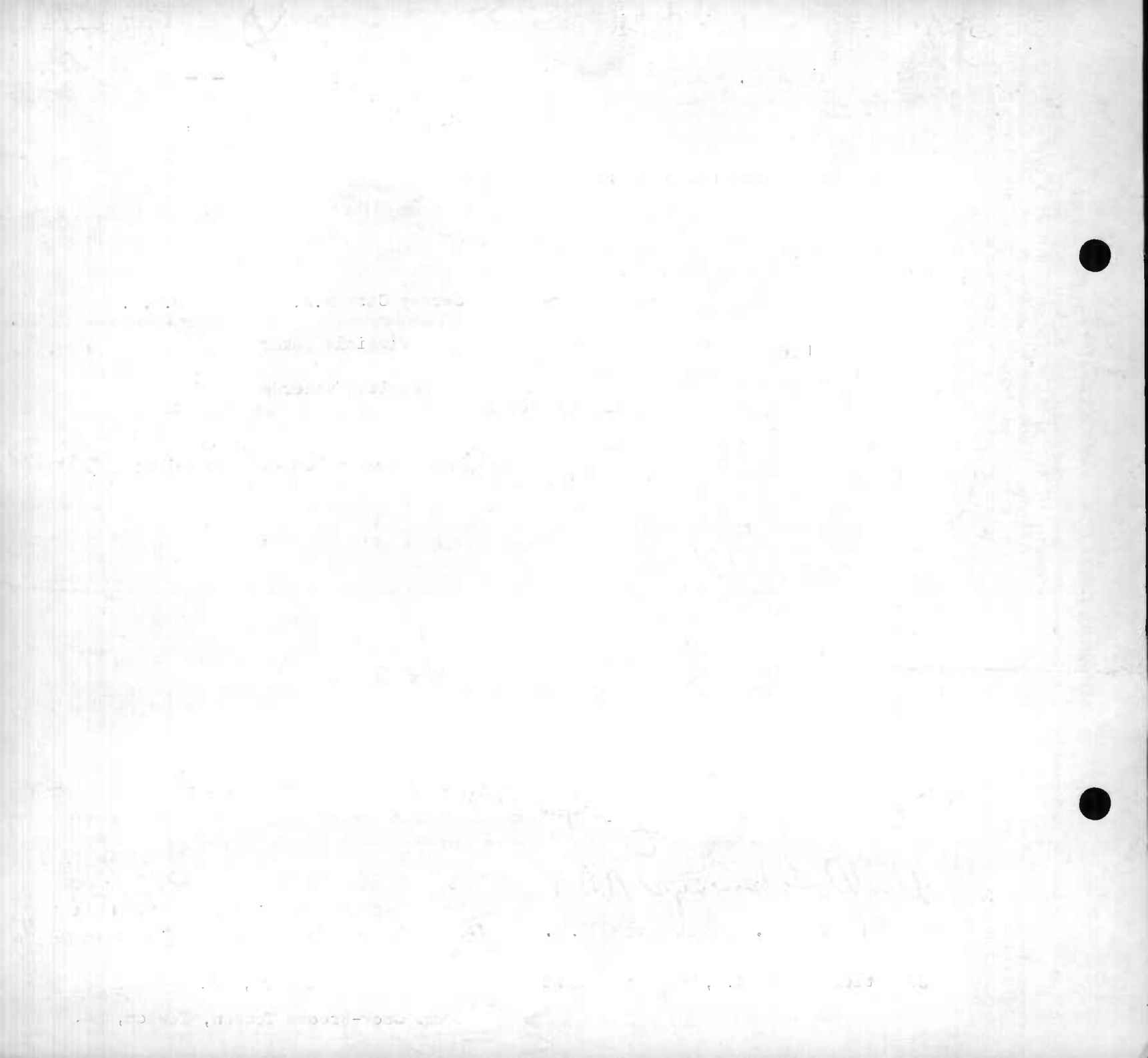
BALTIMORE CITY HEALTH DEPARTMENT
68- 9174 CERTIFICATE OF DEATH

REG. NO. 68- 9174

BIRTH NO.		1. NAME OF DECEASED (Type or Print) IRMA E. FODEN		2. DATE AND HOUR OF DEATH 5:40 PM 9-6-68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6606 DARNALL ROAD, RUXTON, MD 21204			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 10 98	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jersey City N.J.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY SKIFF		14. MOTHER'S MAIDEN NAME Virginia Baker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 158 14 1606 A		17. INFORMANT Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162.1 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Lung with Metastasis to bones (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 163X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1 1968 to Sept 6 1968, that (I) (we) last saw the deceased alive on Sept 6 1968 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wm W. Lukenmeyer M.D.		23B. DATE SIGNED 9/6/68		23C. PHYSICIAN'S NAME (Type) WILLIAM W. LUKENMEYER M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE Sept. 9, 68		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR Robert E. Jackson		24F. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

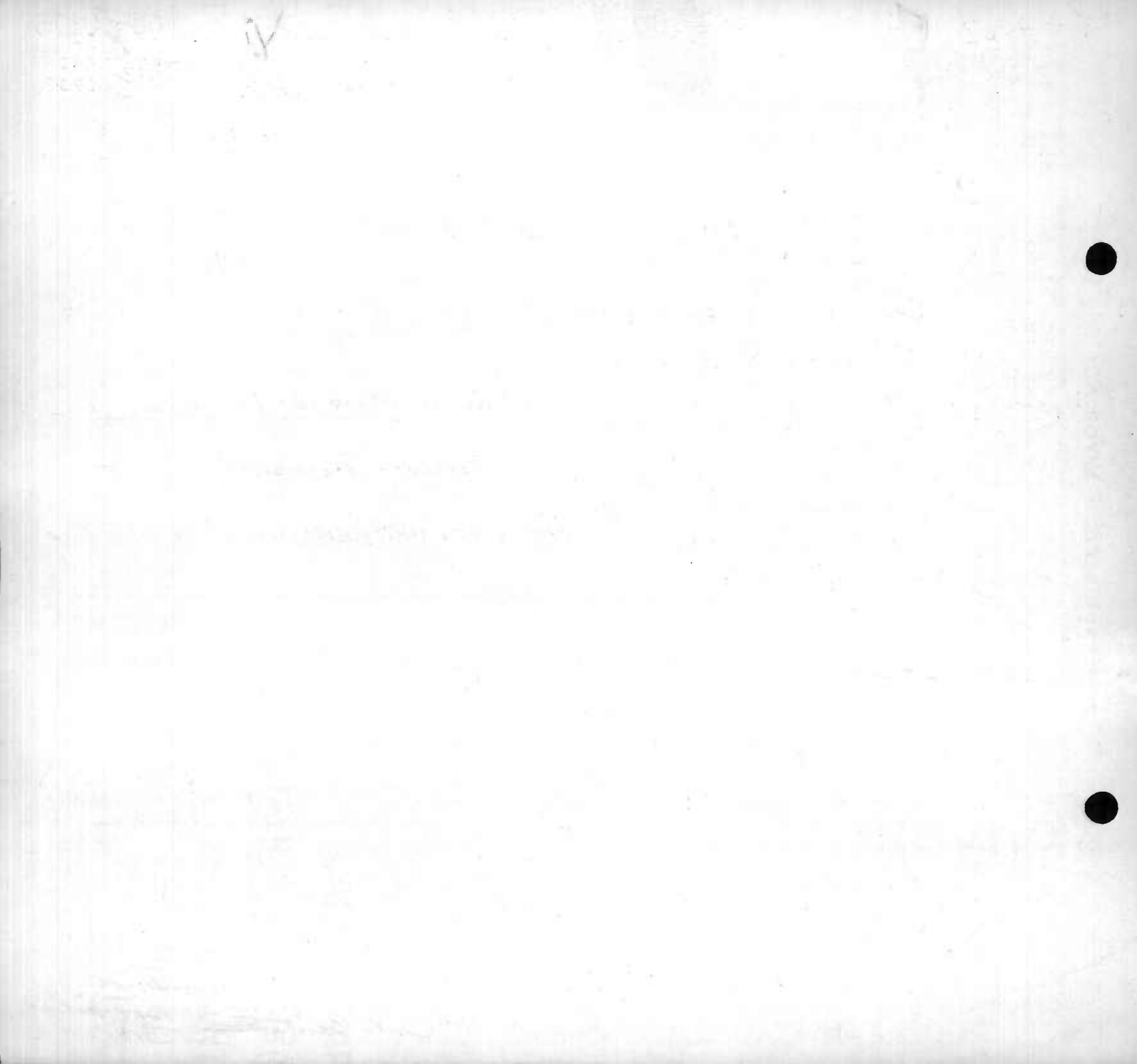


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9175 **CERTIFICATE OF DEATH** REG. NO. 68- 9175

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William Richardson</u>		DATE AND HOUR OF DEATH <u>9-7-68 8:30 AM</u> <u>DR. SAMUEL G. - 15</u> <u>SPCA, M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>HARFORD CO</u>		CITY OR TOWN <u>Darlington</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>Baltimore, Md.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>Route #2</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/5/29</u>	9. AGE (In years last birthday) <u>38</u>	10. AGE (In years last birthday) <u>38</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw. Mill</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Blue Ridge Flooring Co</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Richardson</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Reins - Student Funeral Home</u>	
ADDRESS <u>West Jefferson</u>					
18. <u>46.5</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL THROMBOSIS</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>THROMBOTIC THROMBOCYTOPENIC PURPURA 12 days</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>9-7-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/7</u> 19 <u>68</u> to <u>time of death</u> (8:30 am) and that (I) (we) last saw the deceased alive on <u>9/7</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marcia C. Schmidt MD</u>		23B. DATE SIGNED <u>9/9/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>Marcia C. Schmidt M.D.</u>		23D. ADDRESS <u>University Hospital, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>9-7-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Reins - Student Funeral Home - West Jefferson, N.C.</u>	
24D. LOCATION (City, town, or county) (State) <u>West Jefferson North Carolina</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR <u>IN Cook - Brooks</u>	
ADDRESS <u>1257 North 1st St, Baltimore, Md</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9176

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Margaret M. Birch

2. DATE AND HOUR OF DEATH

9/5/68

5:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1335 Weldon Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1335 Weldon Ave.

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

6/16/1891

9. AGE (In years last birthday)

77

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Williams

14. MOTHER'S MAIDEN NAME

Catherine Grimes

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

George M. Birch - 1335 Weldon Ave.

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Anterobiotic CUD

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1968 to Sept. 4 1968, that (I) (we) last saw the deceased alive on Sept 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edward L. Glassman

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

9/4/68

23C. PHYSICIAN'S NAME (Type)

Edward L. Glassman, MD.

DEGREE

23D. ADDRESS

4037 Falls Rd.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/9/68

24C. NAME of CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 9 1968

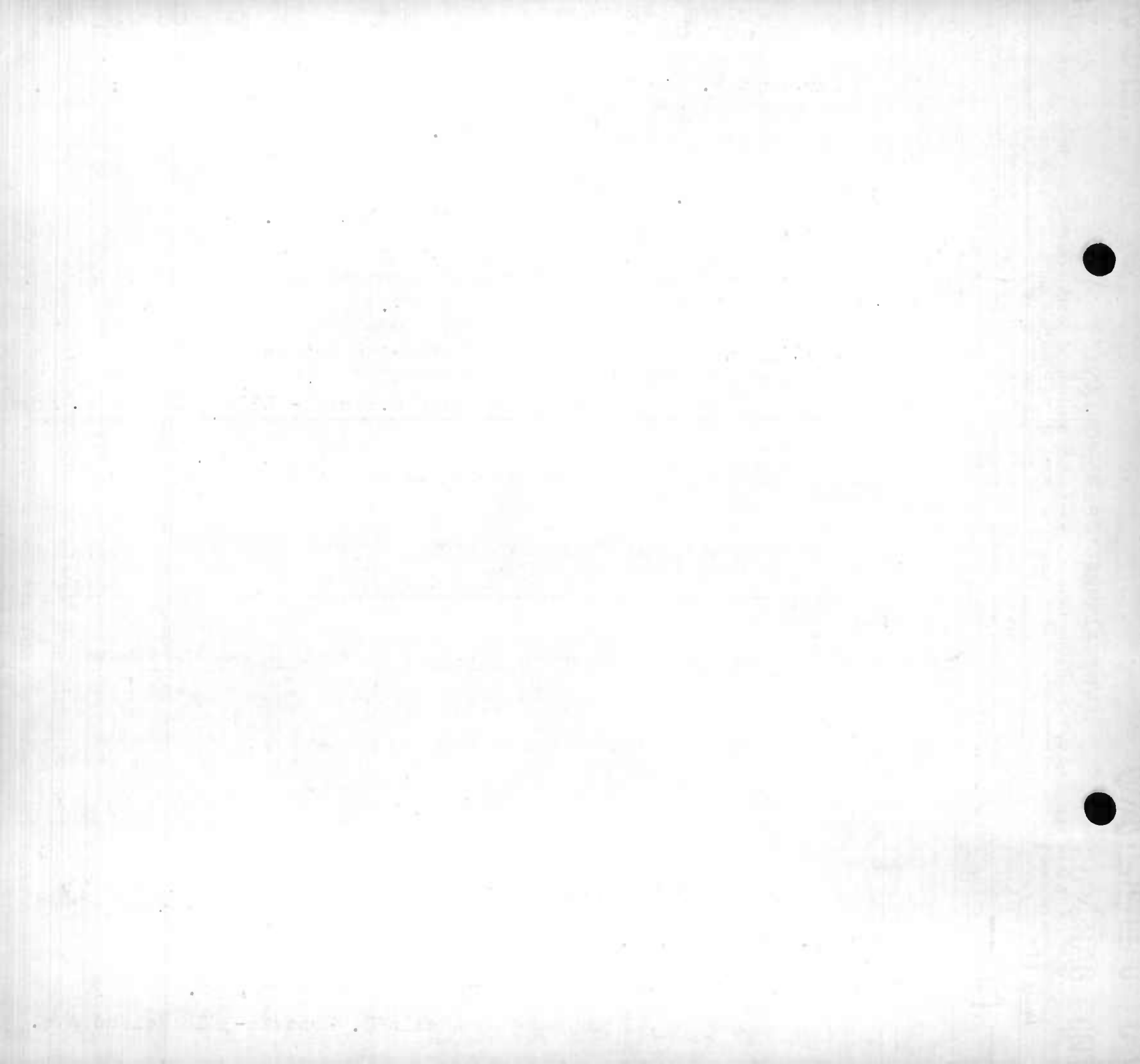
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Austin E. Donovan - 3818 Roland Ave.

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9177

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GLEN WALTER MOREFIELD

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 5, 1968

12:10 P.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Maryland Gen. Hospital
D-01A3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 5, 1968

12:10 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Pennsylvania

B. COUNTY

Chester V-35

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Nottingham

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Mar. 24, 1920

10. AGE (In years
lost birth day)

48

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

R.D. #1

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Morefield

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Tree Trimmer

15. MOTHER'S MAIDEN NAME

Florence Snyder

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

YES

17. SOCIAL
SECURITY NO.

413-16-1275

18. INFORMANT

Ercel L. Morefield - Nottingham, PA

ADDRESS

19.

E812.11

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cerebro-cranial injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

E816.4

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

highway

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR? Rte. #40 - 5/10 mile west
of Rte. #1.

22D. TIME (Month) (Day) (Year) (Hour)

9-1-68 2:55 A. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Sept 8, 1968

24C. NAME of CEMETERY or CREMATORY

Nottingham New Baptist

24D. LOCATION (City, town, or county)

Nottingham, Chester Pa

25A. DATE REC'D BY HEALTH DEPT.

SEP 9 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

RALPH M. REED
Ralph M. Reed

ADDRESS

RISING SUN, MD.

Thompson's

Nov 24 1870

The Farmers

Thompson's

1871

Wm. H. Thompson

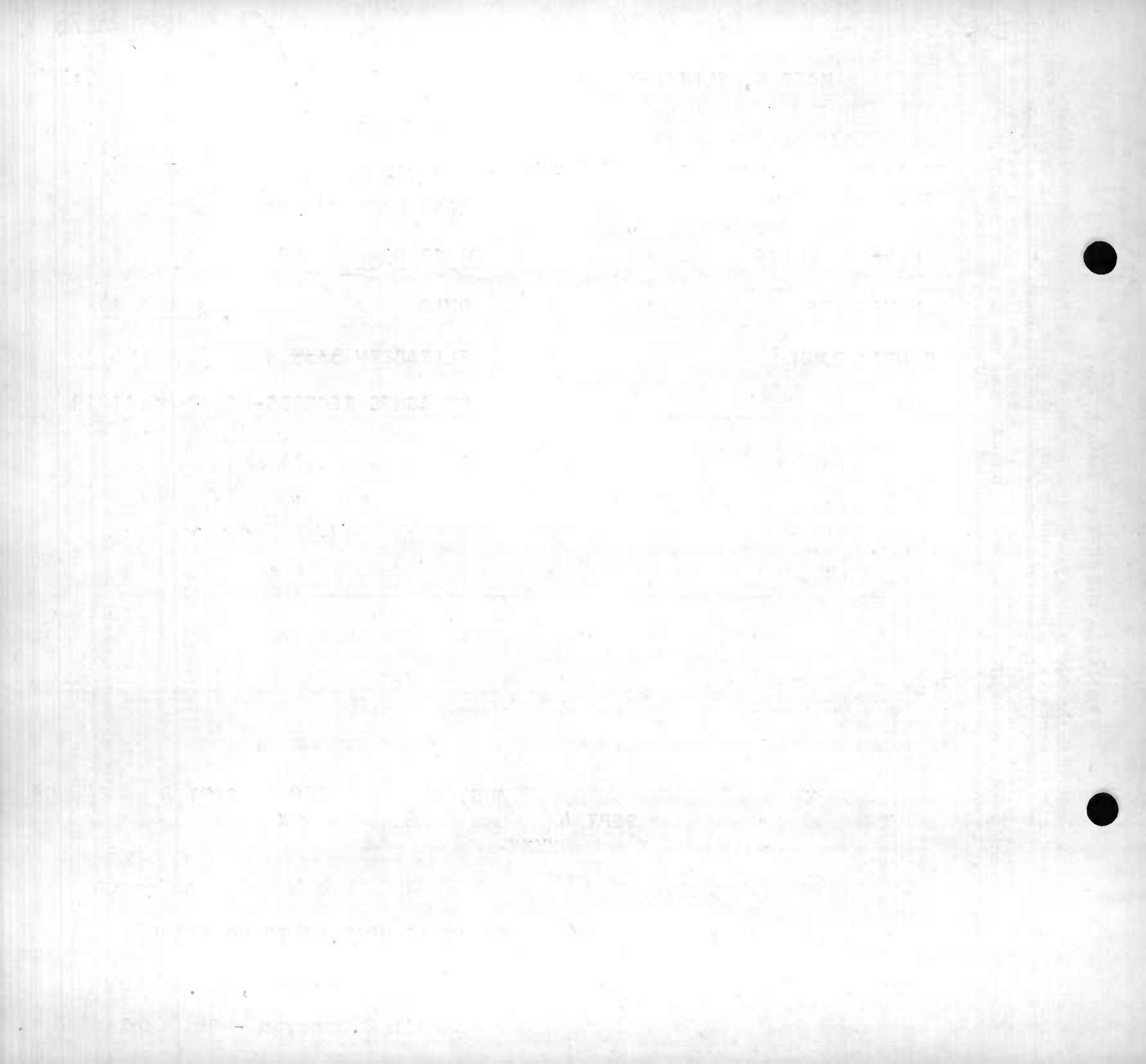
Chas. J. Light

Wm. H. Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9178
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MATTES, ELIZABETH DAUM		SEPT 4, 1968 9:50P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSP. CATON & WILKENS AVE BALTO MD 21229			A. STATE MARYLAND B. COUNTY Baltimore 53-00		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1436 BARRETT ROAD					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06 27 03	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OHIO	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME CONRAD DAUM		14. MOTHER'S MAIDEN NAME ELIZABETH DAUM ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES RECORDS-BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE SUAVANOUS CARCINOMA OF NASAL SINUSES. C (B) METASTASIS TO BRAIN. (C) AND PITUITARY GLAND.		
19. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from AUG. 24 19 68 to SEPT 4 19 68, that (X) (we) lost saw the deceased alive on SEPT 4 19 68 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE Victor A. Borke M.D.			23B. DATE SIGNED 09 05 68		
23C. PHYSICIAN'S NAME (Type) VICTOR ALBORKE M.D.			23D. ADDRESS ST AGNES HOSP. BALTO MD 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/9/68	24C. NAME OF CEMETERY or CREMATORY Dunmore Cemetery		24D. LOCATION (City, town, or county) (State) Scranton, Pa.	
25A. DATE REC'D BY HEALTH DEPT. SEP 9 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS Austin E. Donovan - 3818 Roland Ave.	



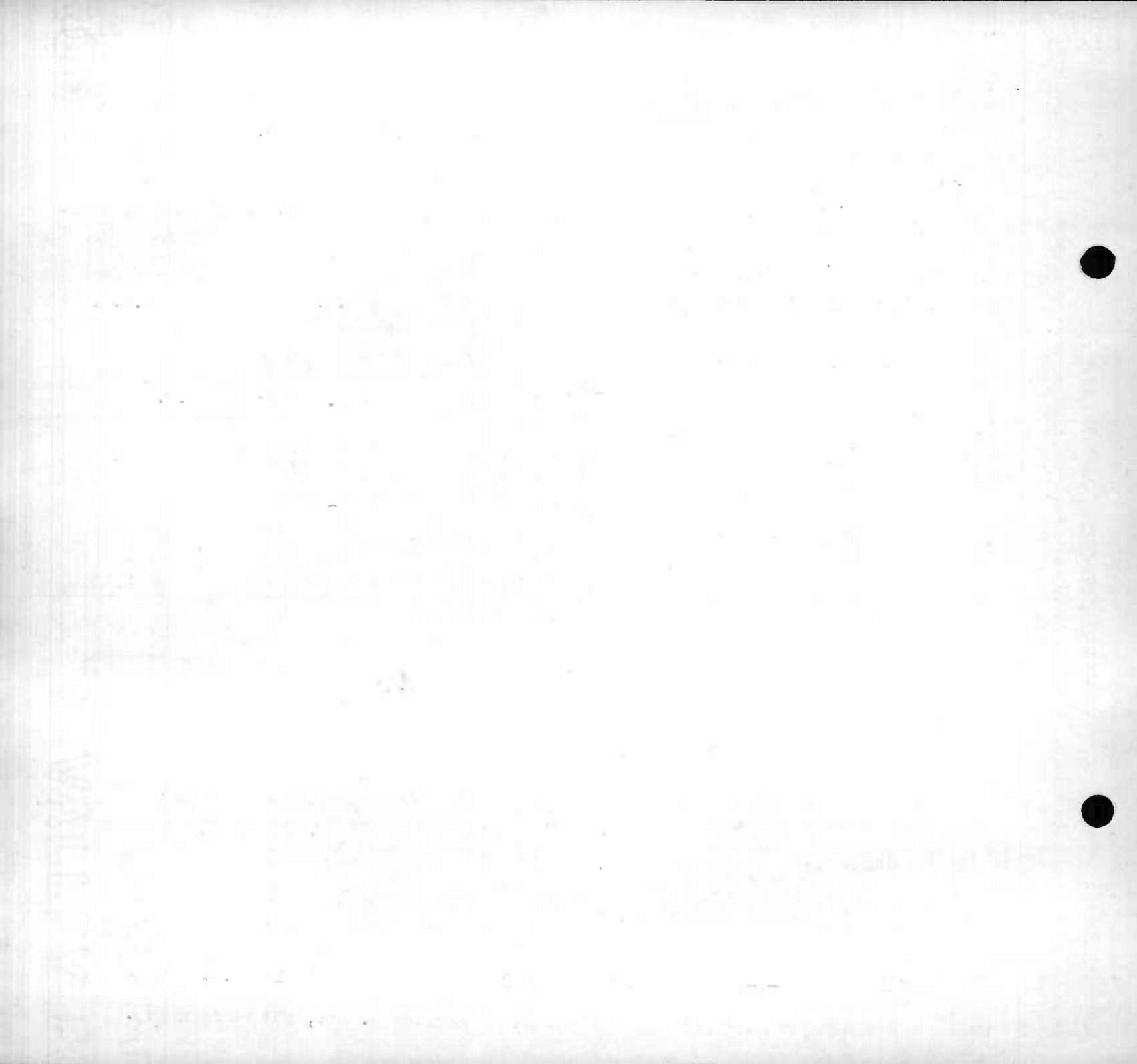
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9179 CERTIFICATE OF DEATH

REG. NO. 68- 9179

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Pearl L. Pennington</u>		2. DATE AND HOUR OF DEATH <u>10:02 AM 9/6/68</u>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> <u>601 N. Broadway, Balto., Md</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>2817 MD</u> <u>14 W. Cold Spring Lane</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19/88</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Federal Accountant</u>			11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Anderson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>083-001-8938</u>		17. INFORMANT <u>Mayme Williams. Washington D.C.</u>		
18. <u>153.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>respiratory arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Disseminated carcinoma of the colon</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>2 years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>153.8 II</u>							
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>7-26</u> 19 <u>68</u> to <u>9-6-68</u> 19 <u>68</u> , that (2) (we) last saw the deceased alive on <u>9-6</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Paul L. Trachtenberg, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/6/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>PAUL L. TRACHTENBERG, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-9-68</u>		24C. NAME of CEMETERY or CREMATORY <u>Lincoln Memorial</u>		24D. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1968</u>		25B. NAME OF REGISTRAR <u>R. L. Taylor</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave.</u>		ADDRESS	



B-6152

68- 9180 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9180

BIRTH NO. 68-11505

REG. NO.

1. NAME OF DECEASED (Type or Print) RANDY BREWINGTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 4, 1968		Hour 11:10 A.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year September 4, 1968		Hour 11:10 A.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 32		
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH June 20, 1968		10. AGE (In years last birthday) 21 1/2 yrs	E. STREET AND NUMBER 2722 Bookers Drive	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF U.S.A.		13. FATHER'S NAME UNKNOWN
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME UNKNOWN
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. NONE		18. INFORMANT ADDRESS FAMILY & CHILDREN'S SOCIETY - 1301 PARK AVE.
19. 484 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 523 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Interstitial Pneumonitis (SDII) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED September 4, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-6-68	24C. NAME of CEMETERY or CREMATORY BALTIMORE CEMETERY	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR ADDRESS CHARLES R. LAW 802 MADISON AVE.

WAIT-LEY

Gen. M. M. M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

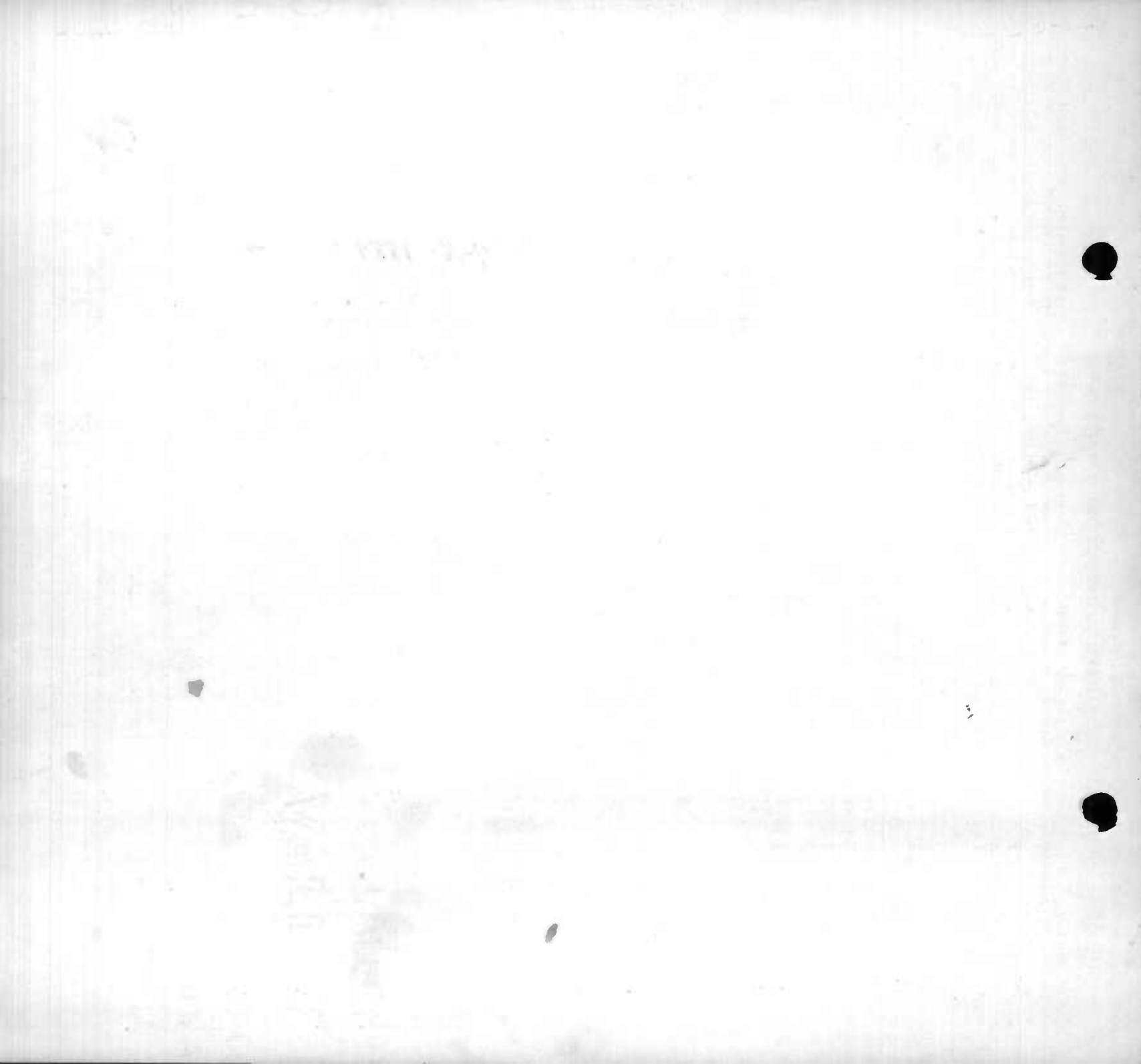
68- 9181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9181

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY M. SHORTS		2. DATE AND HOUR OF DEATH 9/5/68 11⁰⁴ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND 46			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2031 BRADDISH AVE.					
5. SEX F.	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-16-1889	9. AGE (In years lost birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S.			13. FATHER'S NAME John Johnson		
14. MOTHER'S MAIDEN NAME Polly Johnson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.		17. INFORMANT DAUGHTER			
18. 442 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Rupture aneurysm (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: (C) years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS
19. 452 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that the at this hospital attended attended the deceased from 9:50 A.M. 9/5 1968 to 11⁰⁴ A.M. 9/5 1968 , that he (we) last saw the deceased alive on 8/5 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (not) (view) the body after death.					
23A. SIGNATURE Samart Veehongsam M.D.				23B. DATE SIGNED 9/5/68	
23C. PHYSICIAN'S NAME (Type) SAMART VEEHONGSAM M.D.		23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-68		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 9182	
BIRTH NO. 68- 9182		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JACOB SWOPE		2. DATE AND HOUR OF DEATH 8/28/68 6:30 P.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LINCOLN MEMORIAL NURSING HOME		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 29 WEST STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) UNKNOWN	8. DATE OF BIRTH 1890	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) UNKNOWN	
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 4-10-91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CORONARY THROMBOSIS (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) DUE TO (B) DUE TO (C) DUE TO					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 42011 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/12/68 19 to 8/28/68 19, that (I) (we) last saw the deceased alive on 8/28/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D.				23B. DATE SIGNED 9/4/68	
23C. PHYSICIAN'S NAME (Type) H. J. FERNALINE M.D.				23D. ADDRESS 1519 Kensington Ave. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE SEP 5 1968		24C. NAME OF CEMETERY OR CREMATOR ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

2212 Kennedy St, New York

John Kennedy
2212 Kennedy St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9183

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENRY C. DUGAN		2. DATE AND HOUR OF DEATH 9/6/68 1:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2926 Harford Rd.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/08/93	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. from Stationary Engineer			10B. KIND OF BUSINESS OR INDUSTRY Rail Road.		11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA.			13. FATHER'S NAME Worman Dugan		
14. MOTHER'S MAIDEN NAME Agnes Spangler			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown WW I U.S. Army		
16. SOCIAL SECURITY NO.			17. INFORMANT James Dugan, 201 Kingbrook Rd., Linthicum Hgts., Maryland		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 485X1 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) bronchopneumonia Asphyxia pulmonary edema Pneumonia Aspiration			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 min. 15 min. 2 wks.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 491X II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). fg.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/27/68 19 to Sept 6 19 68 , that (I) (we) last saw the deceased alive on Sept. 6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Cohen M.D.				23B. DATE SIGNED 9/6/68	
23C. PHYSICIAN'S NAME (Type) Robert Cohen				23D. ADDRESS Union Memorial Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/10/68		24C. NAME OF CEMETERY or CREMATORY Mummert Meeting House	
24D. LOCATION (City, town, or county) (State) East Berlin, Penna.		25A. DATE RECEIVED BY HEALTH DEPT. SEP 10 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Witzke Fun. Dir.			
25D. ADDRESS 401 Edmondson Ave. Balto., Md. 21229					

Periphrasis

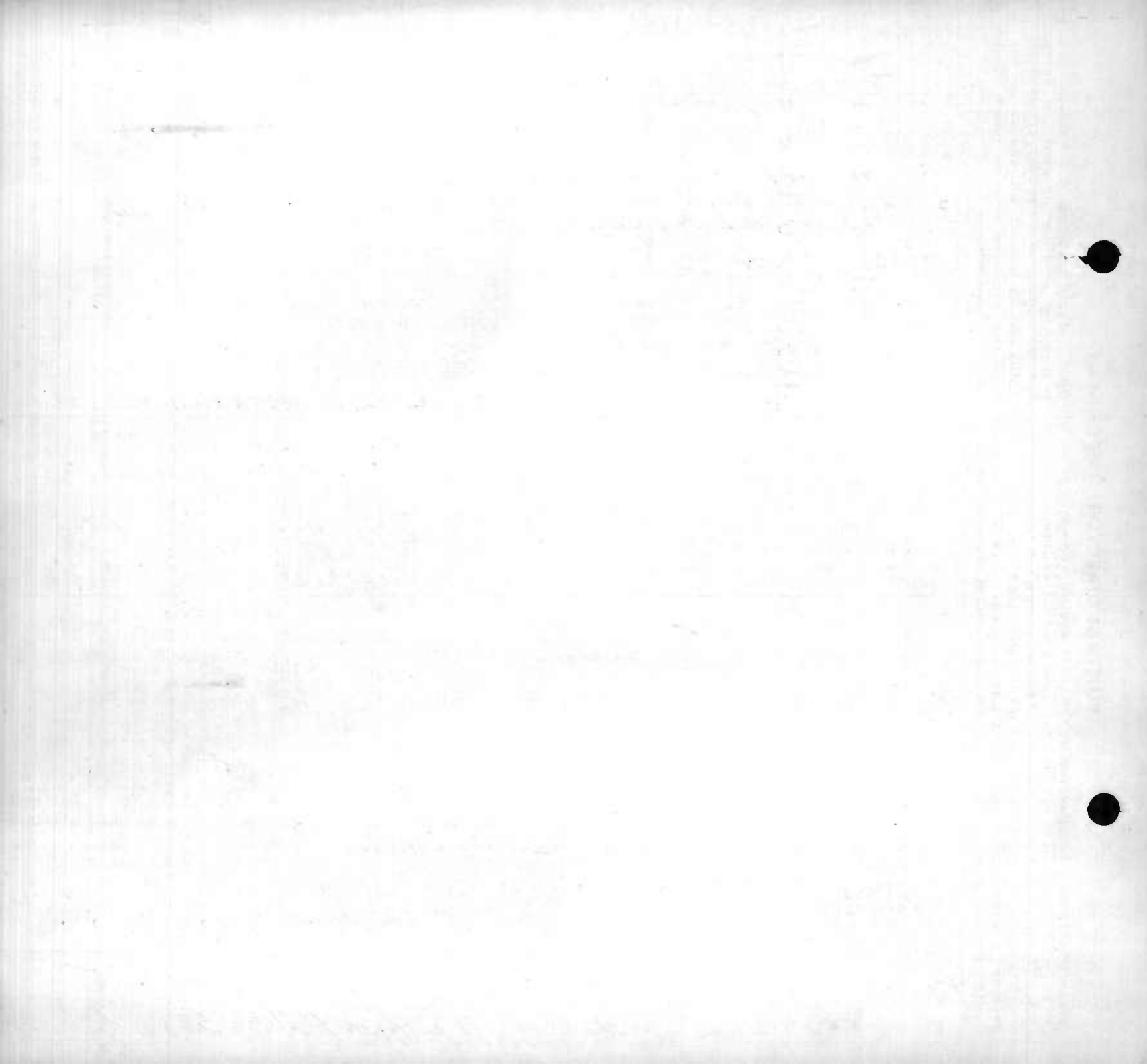
Periphrasis

234

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-252		68- 9184	
1. NAME OF DECEASED (Type or Print) HELEN WASHINGTON		2. DATE AND HOUR OF DEATH SEPT 9, 1968 12 ⁰⁷ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION BALTO CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN BALTIMORE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2862 POTEE ST. 21225			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-25-31
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years last birthday) 37
11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LONNIE STEWART		14. MOTHER'S MAIDEN NAME SALLIE BROWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD		ADDRESS	
18. 01510 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULM EMBOLI		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) POTTS DISEASE DUE TO, OR AS A CONSEQUENCE OF: 1 YR	
(C) TUBERCULOSIS DUE TO, OR AS A CONSEQUENCE OF: 2 YR			
01210 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED.	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from AUG 15 19 68 to SEPT 9 19 68, that (we) last saw the deceased alive on 9/8/ 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE John H. Mitchell M.D.		23B. DATE SIGNED 9-9-68	
23C. PHYSICIAN'S NAME (Type) JOHN H. MITCHELL, M.D.		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. BALTO CITY HOSPITALS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/10/68	
24C. NAME of CEMETERY or CREMATORY Mt Calvary		24D. LOCATION (City, town, or county) (State) BALTO MD 21225	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Marshall P. Hays		ADDRESS 638 N 71st St	



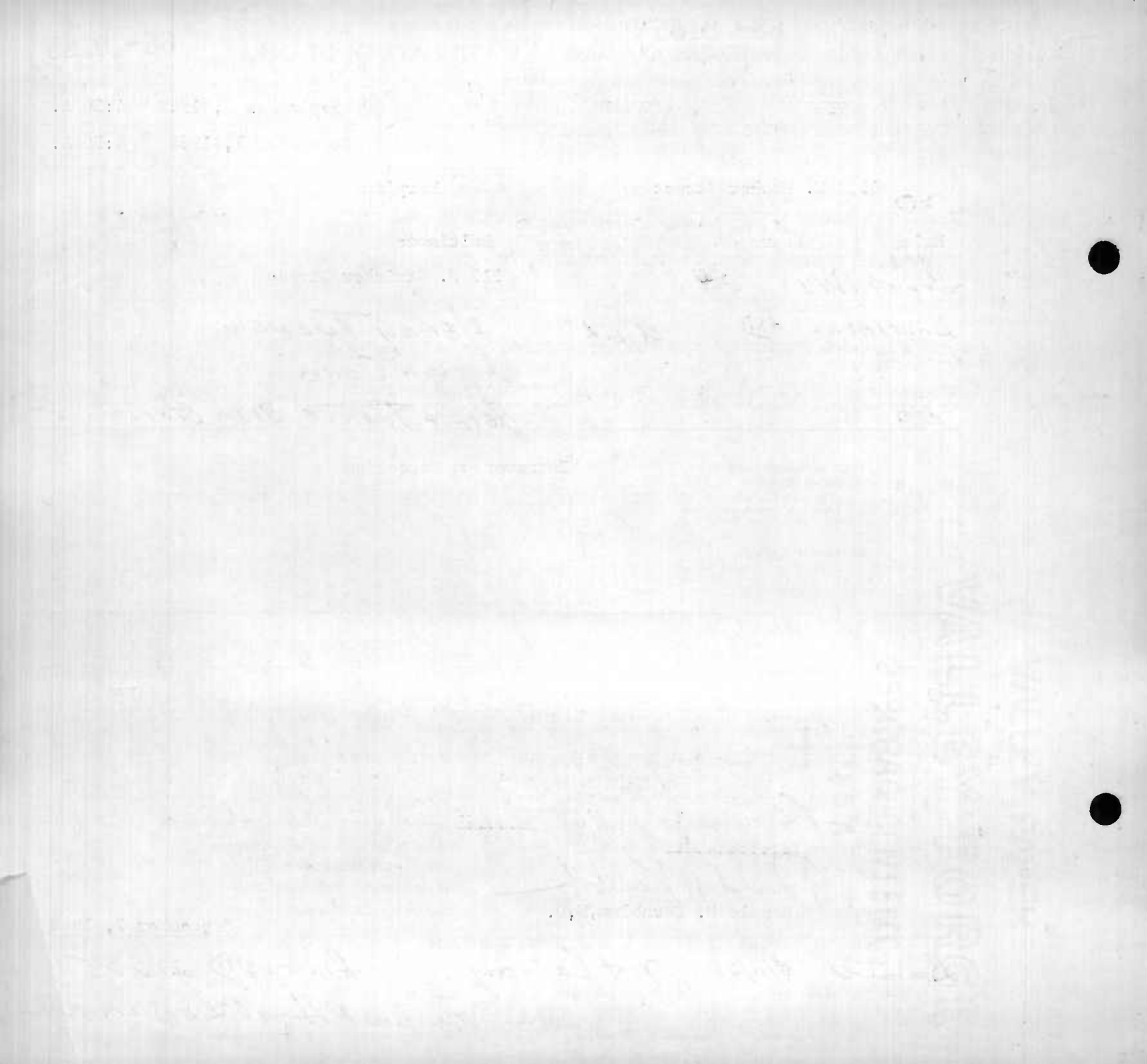
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9185

BIRTH NO.

REG. NO.

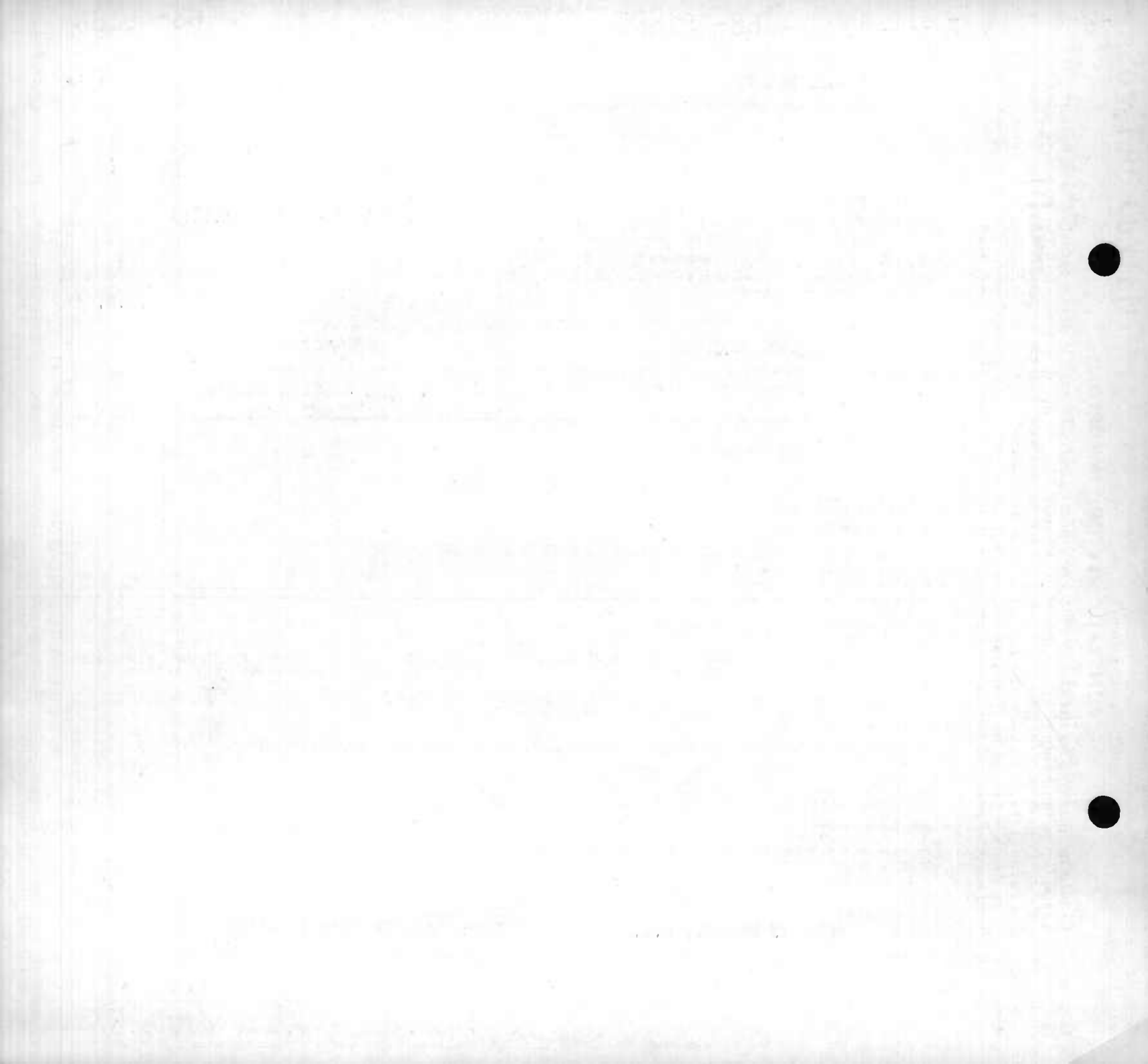
1. NAME OF DECEASED (Type or Print) VERNON TURNER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 7, 1968 Hour 4:30 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1300 W. Mosher Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 7, 1968 4:30 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH July 9-1944		10. AGE (In years lost birthdate) 24 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT HELENIA TURNER		ADDRESS 317 N. Stricker St	
19. 304.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intravenous Narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. 323 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burned		24B. DATE 9/11/68	
24C. NAME of CEMETERY or CREMATORY West Calvary		24D. LOCATION (City, town, or county) (State) Baltimore MD 21225	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Marshall P. Hays		ADDRESS 638 N. Gilman St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

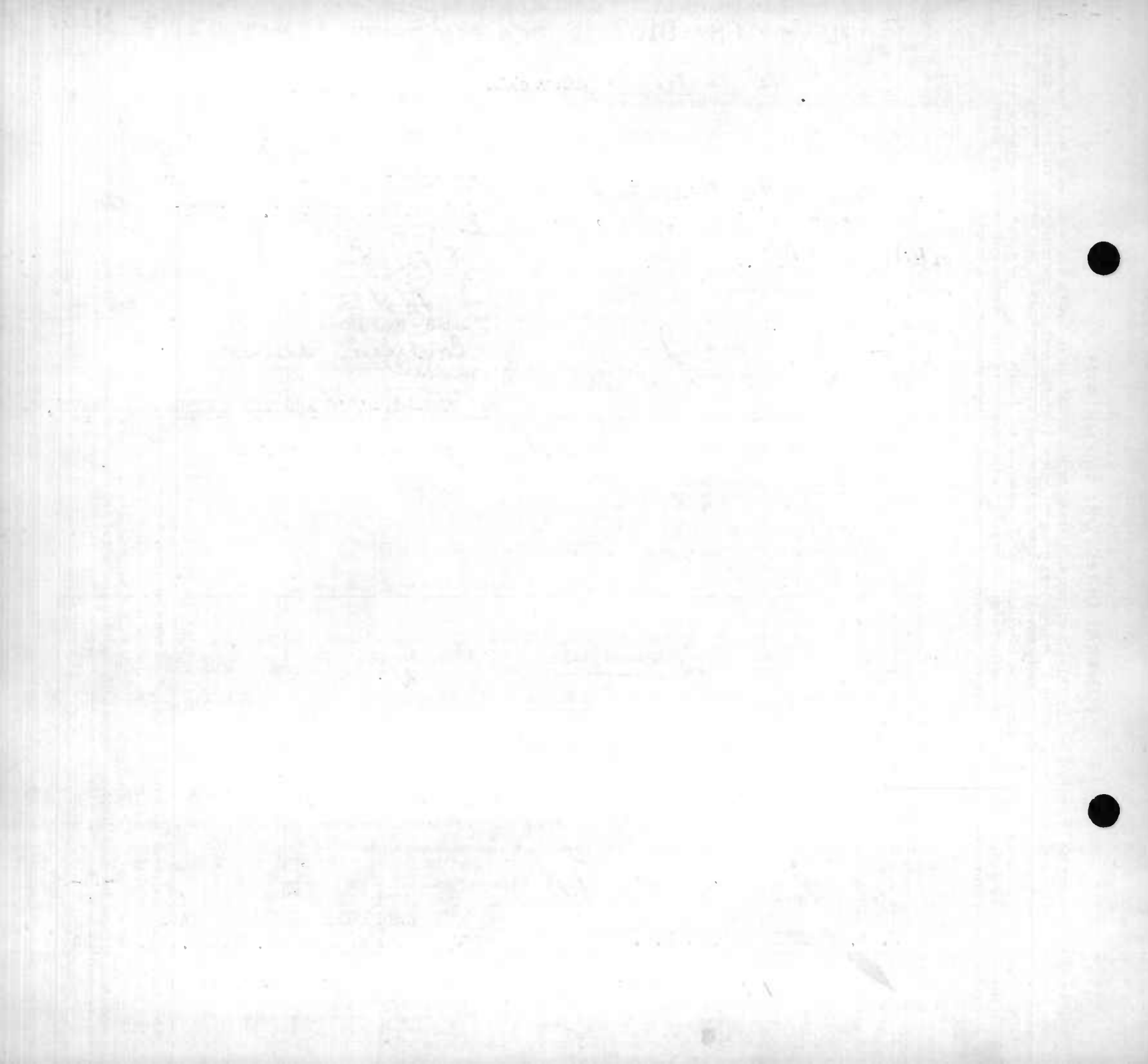
BIRTH NO.		1. NAME OF DECEASED (Type or Print) VIRGIE BROOKS		2. DATE AND HOUR OF DEATH 9/2/68 12:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2604 LOYOLA NORTHWAY #21215	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/91	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME SOLOMON RANDALL				14. MOTHER'S MAIDEN NAME PRUDENCE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224	
18. 20571 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: Chronic granulocytic leukemia (B) Chronic granulocytic leukemia DUE TO, OR AS A CONSEQUENCE OF: (C) Ascup		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/4/ 19 68 to 9/2/ 19 68 , that (I) (we) last saw the deceased alive on 9/2/ 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul R. Kalkut, M.D.		23B. DATE SIGNED 9/2/68			
23C. PHYSICIAN'S NAME (Type) PAUL R. KALKUT, M.D.		23D. ADDRESS BCH: 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/7/68		24C. NAME OF CEMETERY OR CREMATORY St. Catharine	
24D. LOCATION (City, town, or county) Baltimore 21225		(State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Myron R. Jones 635 S. Green St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

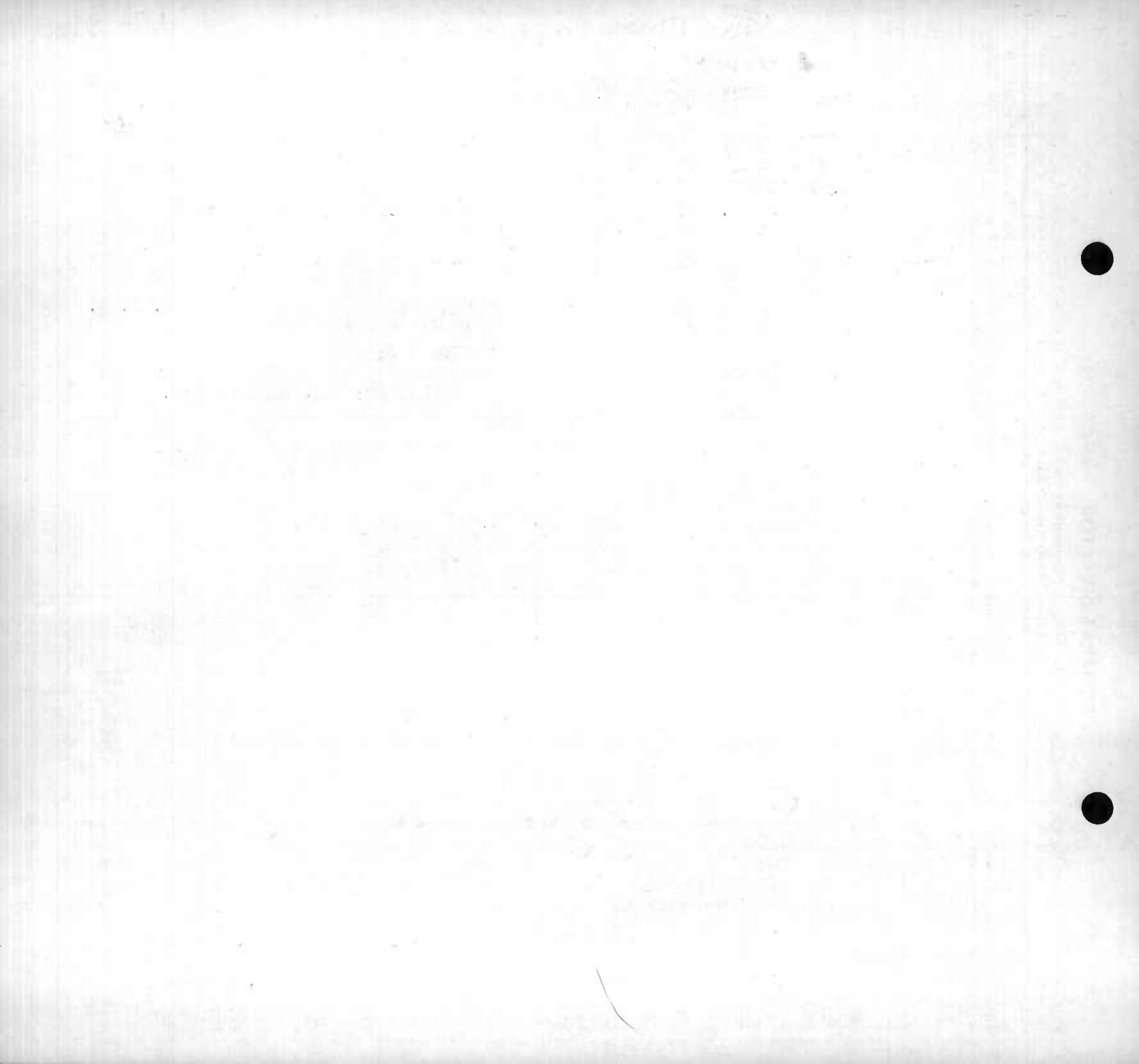
BIRTH NO. 68-14858		68-9187		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9187 4	
1. NAME OF DECEASED (Type or Print) <i>Davis, Baby Boy Cordelia</i>				2. DATE AND HOUR OF DEATH <i>8/12/68</i> <i>140</i> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore City Hospital</i> <i>4940 EASTERN AVENUE, BALTIMORE, MD.</i>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>MARYLAND</i> C. CITY OR TOWN <i>BALTIMORE</i> E. STREET AND NUMBER <i>404 POPLAR GROVE ST. #21223</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/12/68</i>	9. AGE (In years last birthday) <i>2</i>	If Under 1 Yr. Months <i>2</i>	Days <i>55</i>	If Under 24 Hrs. Hours <i>55</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John W Davis Jr.</i>				14. MOTHER'S MAIDEN NAME <i>Cordelia Saunders</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>REC ORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD</i>			
18. <i>777X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>extreme prematurity</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3hr.</i>	
19. <i>776X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1100</i> <i>8/12</i> <i>1968</i> to <i>140</i> <i>8/12</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>139</i> <i>8/12</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. A. SENSENBRENNER MD</i>				23B. DATE SIGNED <i>8-12-68</i>		23C. PHYSICIAN'S NAME (Type) <i>J. A. SENSENBRENNER, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATED</i>		24B. DATE <i>9/6/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE CITY HOSPITALS</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 10 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Smith</i>		25C. FUNERAL DIRECTOR <i>HOSPITAL DISPOSAL</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

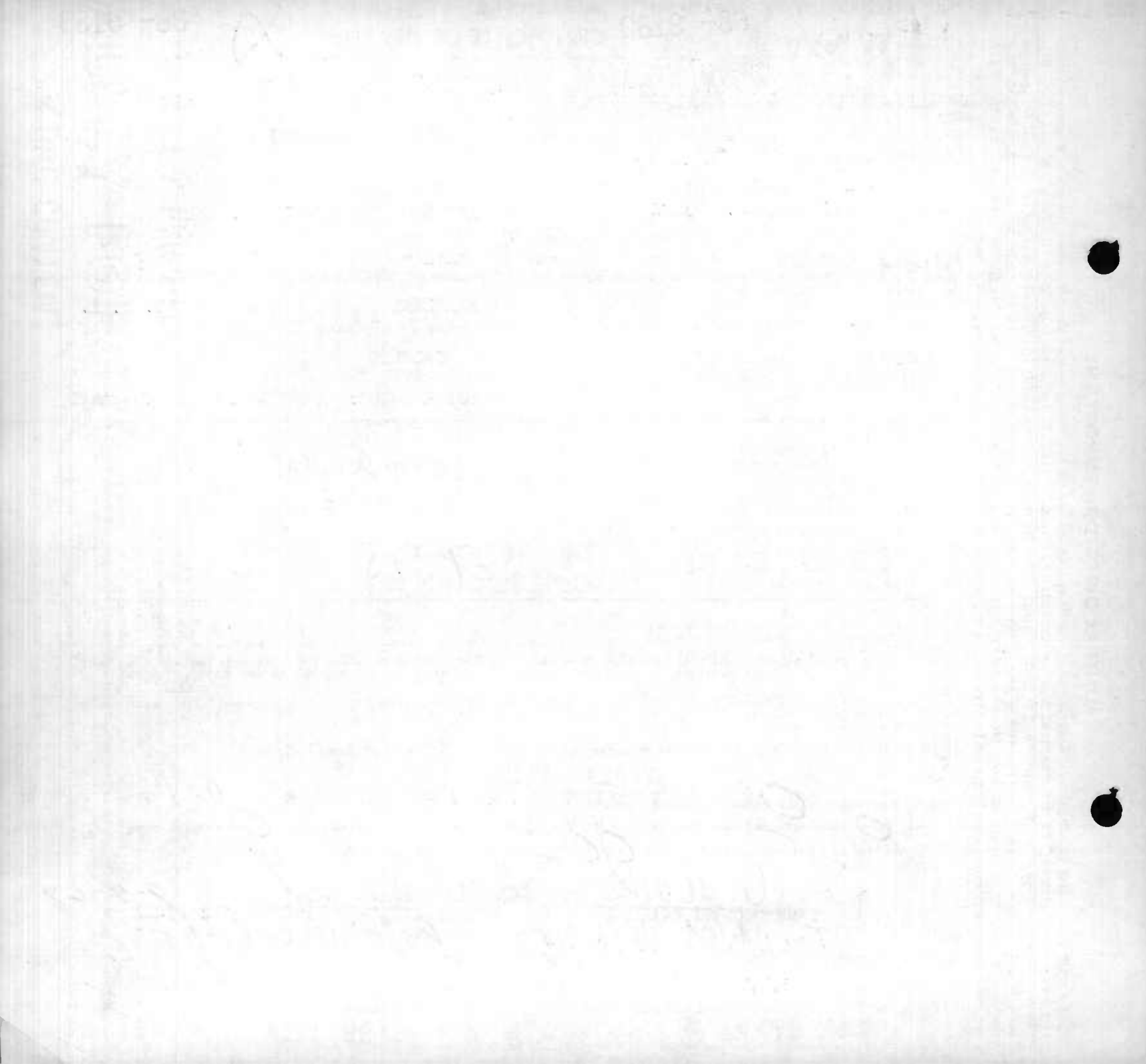
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9188 4	
<div> <div>52-56-12</div> <div>68-9188</div> <div>0-216</div> </div> <div> <div>BIRTH NO. 0-216</div> <div>1. NAME OF DECEASED (Type or Print) OSBURN, BABY BOY-VIOLET JEAN</div> <div>2. DATE AND HOUR OF DEATH 9-3-68 7:05 P.M.</div> </div>					
<div>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</div> <div>BALTIMORE CITY HOSPITALS</div> <div>31 4940 EASTERN AVENUE</div> <div>BALTIMORE, MD. 21224</div> </div>			<div>4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)</div> <div> <div>A. STATE MARYLAND</div> <div>B. COUNTY</div> <div>C. CITY OR TOWN BALTIMORE</div> <div>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> <div>E. STREET AND NUMBER 4813 EASTERN AVENUE 21224</div> </div>		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-68	9. AGE (In years last birthday)	<div>If Under 1 Yr. Months: Days: Hours: Min.</div> <div>21</div>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME CARL			14. MOTHER'S MAIDEN NAME VIOLET JEAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS BCH RECORDS: 4940 EASTERN AVE. 21224		
<div>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div> <div>761.1 I</div> <div>CARDIO RESPIRATORY ARREST</div> <div>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INFANT of DIABETIC MOTHER</div> <div>(B) DUE TO, OR AS A CONSEQUENCE OF: MOTHER</div> <div>(C)</div> </div>					
<div>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</div> <div>769.1 II</div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<div>22. I certify that (I) (this hospital) attended the deceased from 9-2-68 1968 to 9-3-68 1968, that (I) (we) last saw the deceased alive on 9-3-68 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
23A. SIGNATURE FERNANDO VELASQUEZ			23B. DATE SIGNED 9-4-68		23C. PHYSICIAN'S NAME (Type) FERNANDO VELASQUEZ
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATED			24B. DATE 9/5/68		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CITY HOSPITALS
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND			24E. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

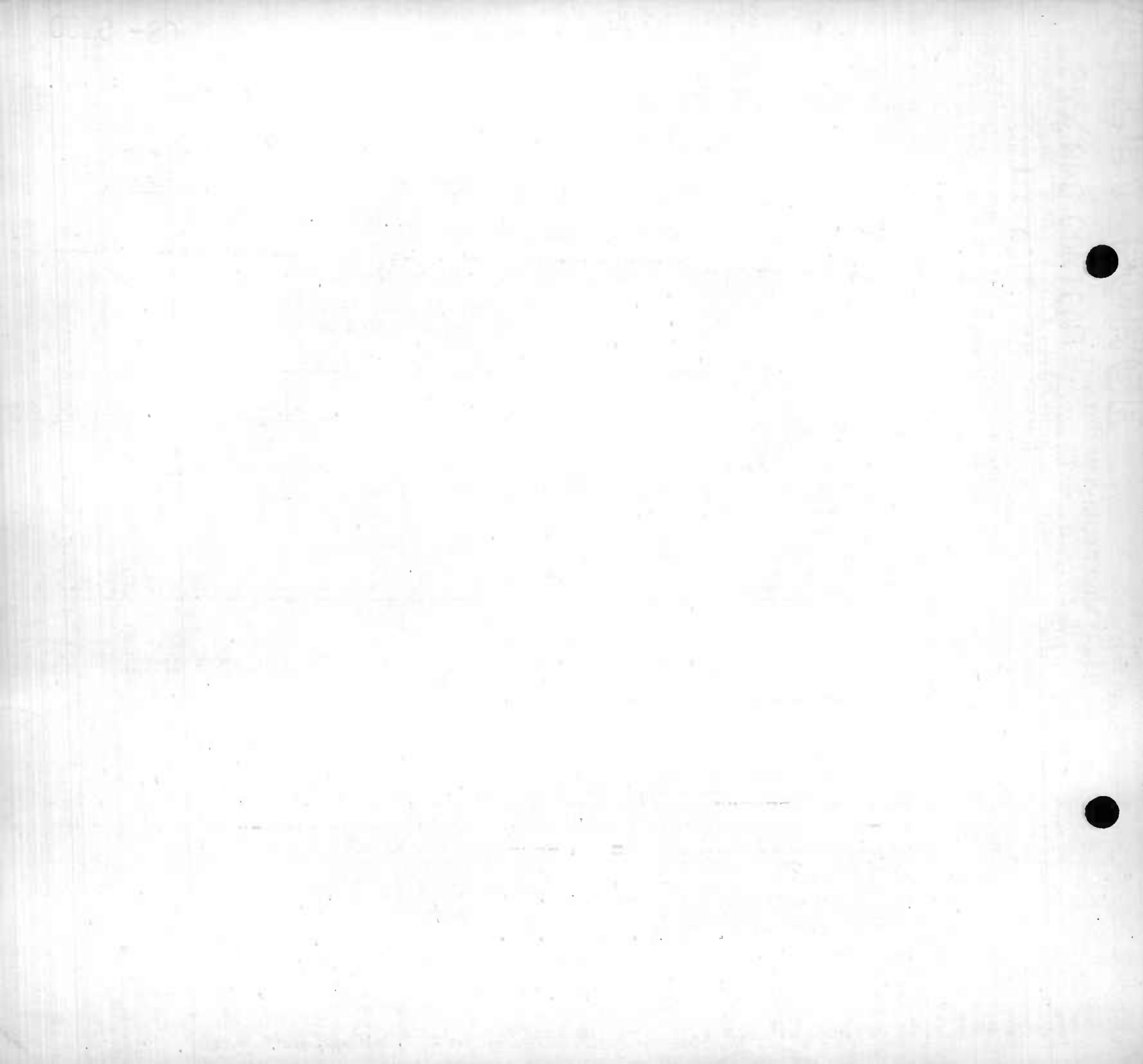
T-653		68- 9189		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. X		68- 9189	
BIRTH NO. 68-16390		1. NAME OF DECEASED (Type or Print) THORNTON BABY GIRL-CAROLYN		2. DATE AND HOUR OF DEATH 9-4-68		1:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 409 BACK RIVER NECK RD. 21221									
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-68		9. AGE (In years last birthday) 3	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLIE				14. MOTHER'S MAIDEN NAME CAROLYN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT BCH RECORDS: 4940 EASTERN AVE. 21224		ADDRESS	
18. 038.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIOVASCULAR COLLAPSE (B) DUE TO, OR AS A CONSEQUENCE OF: SEPSIS (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 053.4 II									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9-1-1968 to 9-4-1968, that (I) (we) last saw the deceased alive on 9-4-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE FERNANDO VELASQUEZ				23B. DATE SIGNED 9-4-68					
23C. PHYSICIAN'S NAME (Type) FERNANDO VELASQUEZ		23D. ADDRESS 4940 EASTERN AVE. 21224 BALTIMORE CITY HOSPITALS							
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATED		24B. DATE 9/5/68		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CITY HOSPITALS		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9190
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lillian Heinbuch</i>		2. DATE AND HOUR OF DEATH <i>September 8, 1968</i> <i>8:30 A.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1-02</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Ardleigh Nursing Home</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>214 S. Robinson Street</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/16/187</i>	9. AGE (In years lost birthday) <i>87</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>Charles Hines</i>			14. MOTHER'S MAIDEN NAME <i>Carrie Loesch</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Miss Myrtle L. Heinbuch</i>	
				ADDRESS <i>214 S. Robinson St</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic cardiovascular disease</i> (B) <i>Hiatus hernia</i> (C) <i>Diabetes mellitus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs.</i> <i>5 yrs.</i> <i>2 yrs.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 28, 1967</i> to <i>September 8, 1968</i> , that (I) (we) last saw the deceased alive on <i>August 28, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i>				23B. DATE SIGNED <i>Sept. 9, 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>Lloyd E. Saylor</i>		23D. ADDRESS <i>3902 Greenmount Avenue</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/12/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 10 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Tankersley</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>	
				ADDRESS <i>3000 E. Baltimore St</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9191

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE CAWUNDER

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

September 5, 1968

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 5, 1968

11:55 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒NO ☐

E. STREET AND NUMBER

717 Argonne Drive

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

(DOA)

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

Nov. 11, 1901

10. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ret. (Electrical planner)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

unknown

18. INFORMANT

ADDRESS

Mildred H. Cawunder 717 Argonne Drive

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/7/68

24C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION (City, town, or county)

Baltimore county

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

SEP 10 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

John A. Moran, Inc.

ADDRESS

3000 E. Balto. St.

Department of Agriculture

Charles J. Smith
Director of the Bureau of Plant Industry

QUALITY PROTECTED
REGISTERED
MADE IN U.S.A.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9192

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK LAWSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 8, 1968 8:20 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 205 N. Ellwood Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 8, 1968 8:30 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/2/'27		10. AGE (In years lost birthday) 40	
11. BIRTHPLACE (State or foreign country) Dolanshire		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Lawson		14. MOTHER'S MAIDEN NAME Mary M. Skaida	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		18. SOCIAL SECURITY NO. UW2	
19. CAUSE OF DEATH E9551X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gunshot wound of Head (b) DUE TO, OR AS A CONSEQUENCE OF: (c) _____	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 976X		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
23A. DATE OF OPERATION 2		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		24B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
24C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 205 N. Ellwood Avenue (Bedroom)		24D. HOW DID INJURY OCCUR? Shot self in head	
25. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) Sept. 8, 1968 12:00 PM.		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
29. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		30. DATE SIGNED September 8, 1968	
31. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		32. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery, Baltimore, Maryland	
33. DATE REC'D BY HEALTH DEPT. SEP 10 1968		34. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Baltimore St.	

COMMONS

HOUSE OF COMMONS

WALLACE

HOUSE OF COMMONS

HOUSE OF COMMONS

HOUSE OF COMMONS

HOUSE OF COMMONS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

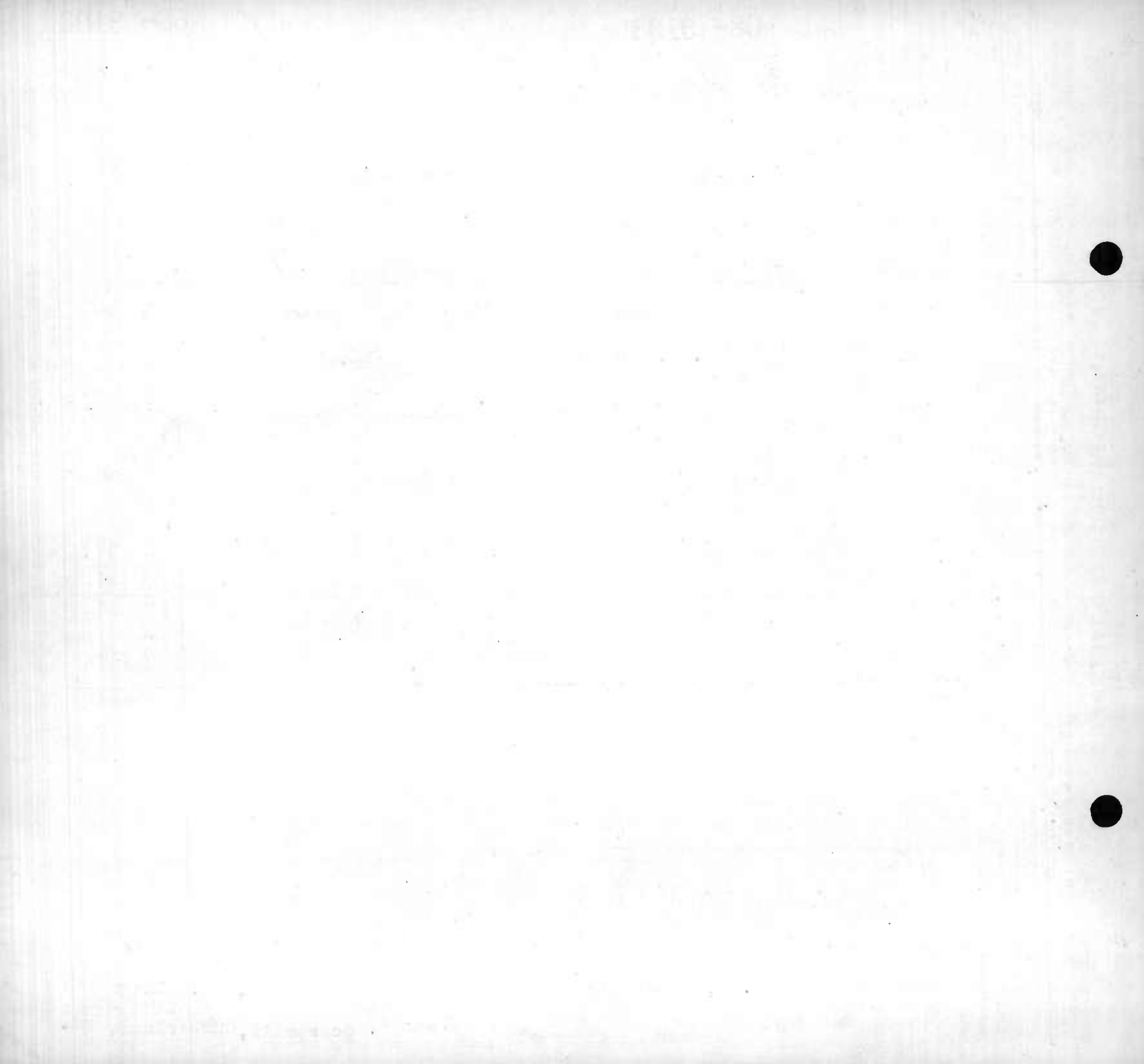
68- 9193 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9193

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Lela B. Welsh</u> <u>Lela B. Welsh</u>		2. DATE AND HOUR OF DEATH <u>9/8/68</u> <u>4 45</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>			A. STATE <u>MD.</u> B. COUNTY <u>Allegany Co</u> <u>51-02</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Cumberland</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>240 E. Elder</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10/6/01</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Garrett Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>E. Bosely</u> <u>Wm. H. Bosley</u>			14. MOTHER'S MAIDEN NAME XXXXXXXX <u>Eliza Kuhn</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-16-4057</u>	17. INFORMANT ADDRESS <u>Mrs Twily</u> <u>2200 Plymouth Falls Church Va.</u>		
18. <u>180X + R50.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Ca of Cervix</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
171X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes Mellitus</u>					
19A. DATE OF OPERATION <u>7/9/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>possible exenteration</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>7/2/68</u> 19 to <u>9/8/68</u> 19, that (1) (we) last saw the deceased alive on <u>9/8/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dewitt E Kemp MD</u>				23B. DATE SIGNED <u>9/8/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dewitt E Kemp III MD</u>		23D. ADDRESS <u>3602 Kelox Rd Balto MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Sept. 11, 1968</u>	24C. NAME of CEMETERY or CREMATORY <u>Hillcrest Burial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Cumberland, Md. Allegany</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>James F. Scarpelli, Cumberland, Md.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9194

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) WILLIAM ERNEST FELTER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 6, 1968		Hour 1:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL (DOA)				3. DATE PRONOUNCED DEAD Month Day Year September 6, 1968		Hour 1:30 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 402 E. Lorraine Avenue	
9. DATE OF BIRTH Feb. 17th, 1905		10. AGE (In years lost birthday) 63		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Wyoming, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John H. Felter			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber-Steam fitter				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME Jessie Young				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes ww-2			
17. SOCIAL SECURITY NO. 578-01-6303				18. INFORMANT Mr. Cletus Felter-402 Lorraine Avenue-18			
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. 422.7 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL EXAMINER'S SIGNATURE Edward F. Wilson, M.D. M.D. NAME (Type) DATE SIGNED September 7, 1968							
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 9/10/68		24C. NAME of CEMETERY or CREMATORY Balto. Nat'l. Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Road 21212	

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

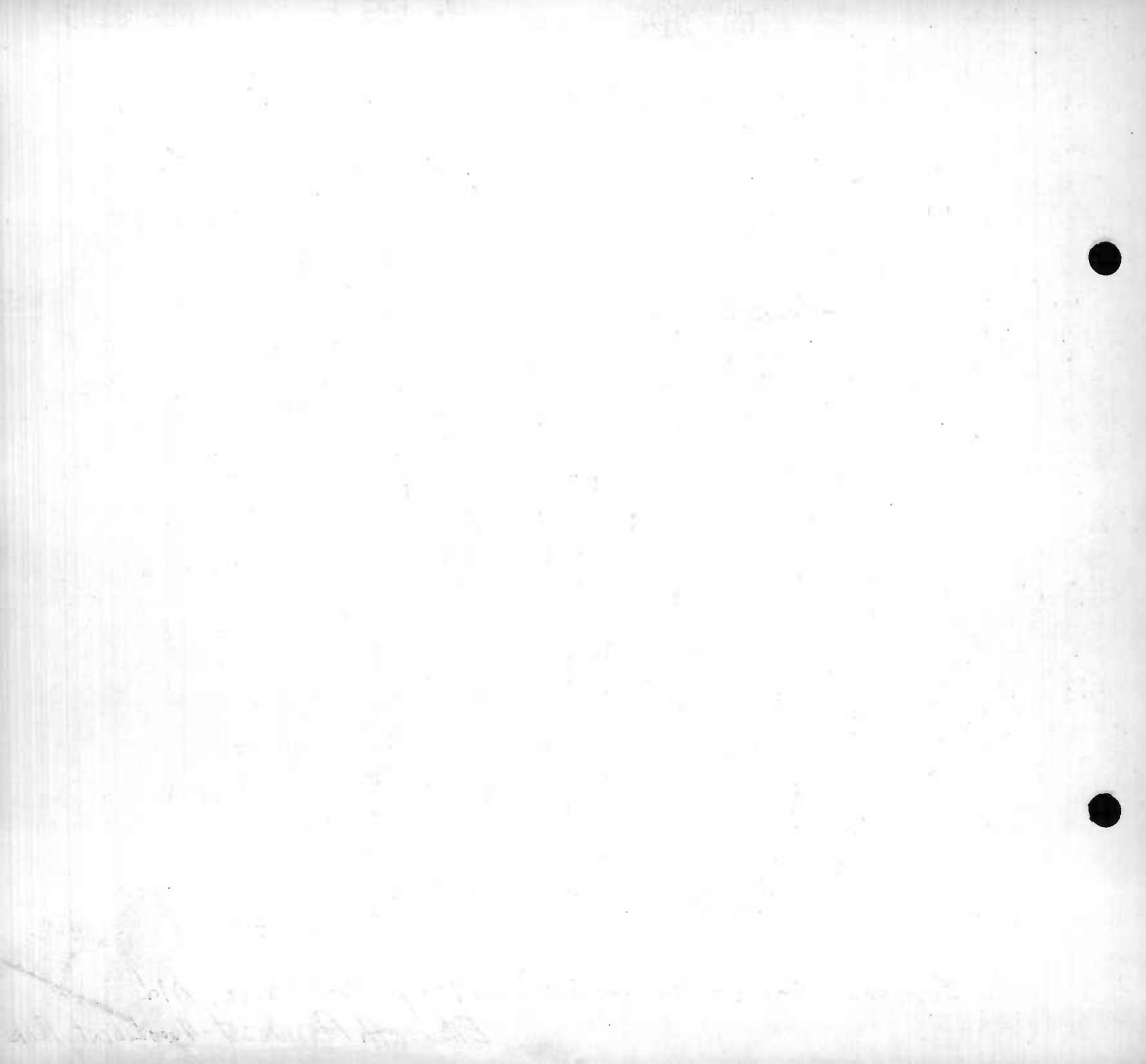
100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO.		68- 9195		
BIRTH NO.										68- 9195				
1. NAME OF DECEASED (Type or Print) George Henry Schwartz					2. DATE AND HOUR OF DEATH Sept. 8, 1968 1:55 PM M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore									
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital 48					C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER 5111 Brook Green Road 21229									
5. SEX Male		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07/23/86		9. AGE (In years lost birthday) 82		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher - PERSONNEL					10B. KIND OF BUSINESS OR INDUSTRY Balto. City Schools					11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John G. Schwartz					14. MOTHER'S MAIDEN NAME Schlerf									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 215 07 8164		17. INFORMANT Mrs. Cordelia Schwartz (wife)			ADDRESS 4E, above				
18. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CVA (cerebral thrombosis)					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) DUE TO, OR AS A CONSEQUENCE OF:														
19. DATE OF OPERATION 422.1 II					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>July 19 19 68</u> to <u>Sept 8 19 68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Sept. 8 19 68</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(We)</u> <u>(did)</u> (did not) view the body after death.														
23A. SIGNATURE Richard C. Keech M.D.										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/8/68		
23C. PHYSICIAN'S NAME (Type) Richard C. Keech										23D. ADDRESS 827 Linden Ave., Balto., Md. 21201				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 9-11-68		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery, Baltimore, Md.			24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968					25B. NAME OF REGISTRAR Robert E. Jackson					25C. FUNERAL DIRECTOR Ellsworth Armacost - 4600 Liberty Hts				



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9196

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) THOMAS D. JENKINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 6, 1968 8:15 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5008 Blythe Wood Road		3. DATE PRONOUNCED DEAD Month Day Year Hour September 6, 1968 8:15 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov. 21, 1942		10. AGE (In years last birthday) 26 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas D. Jenkins		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore City Water Dept.	
15. MOTHER'S MAIDEN NAME Yowell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. 217-40-1341		18. INFORMANT Elizabeth C. Jenkins 840 Powers St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E952.0 Asphyxia due to Carbon Monoxide		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E973.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Truck	
22C. WHERE DID INJURY OCCUR? 5008 Blythe Wood Road		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Sept. 5-6, 1968 ???	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted exhaust, Asphyxia	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED September 6, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE (/9-1968	
24C. NAME OF CEMETERY or CREMATORY St. Marys (Hampden)		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Fadden	
25C. FUNERAL DIRECTOR Frank H. Lutz		ADDRESS 814 N 36th St	

20-40-1341

WALKER POLICE

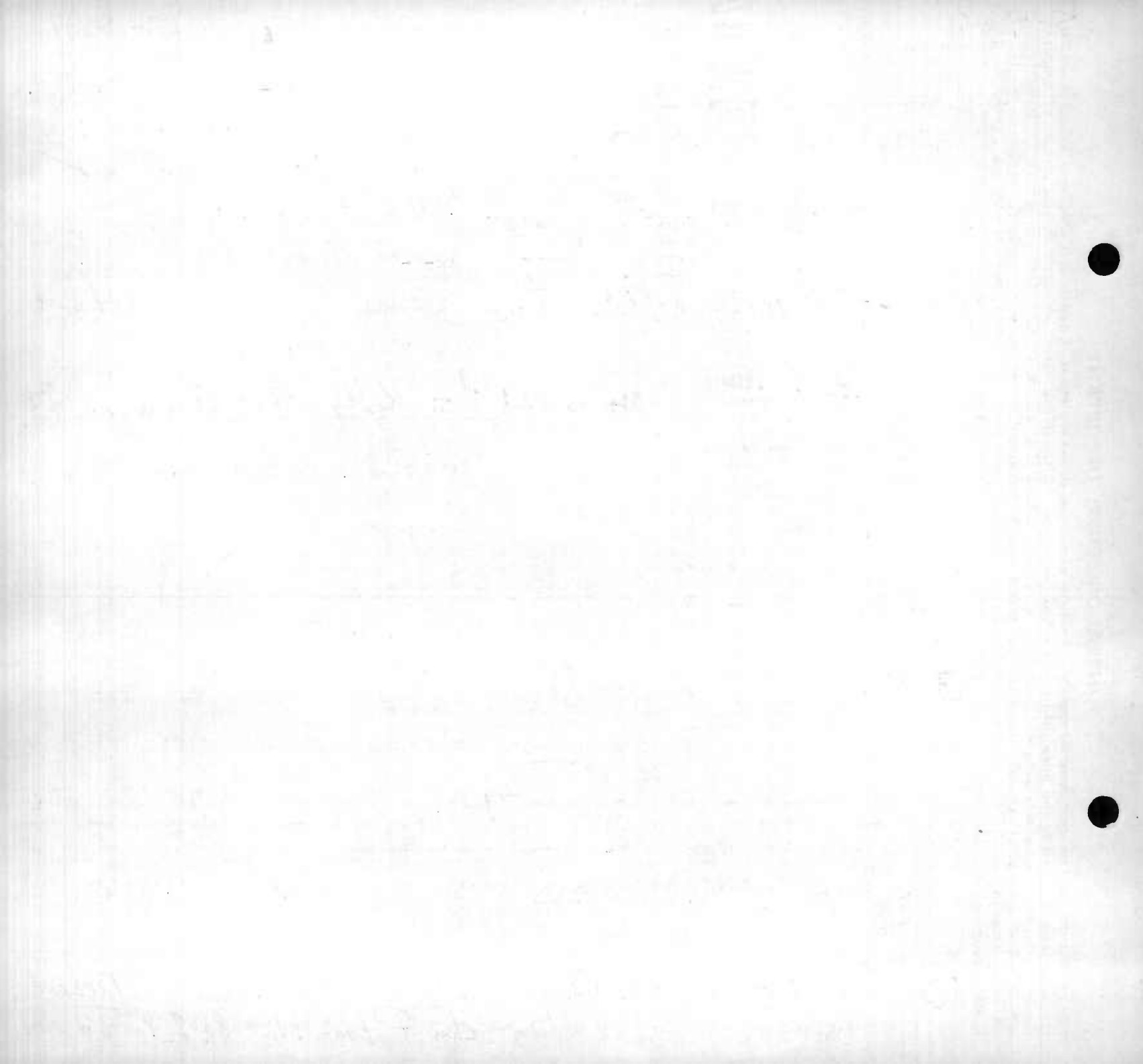
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9197 CERTIFICATE OF DEATH

REG. NO. 68- 9197

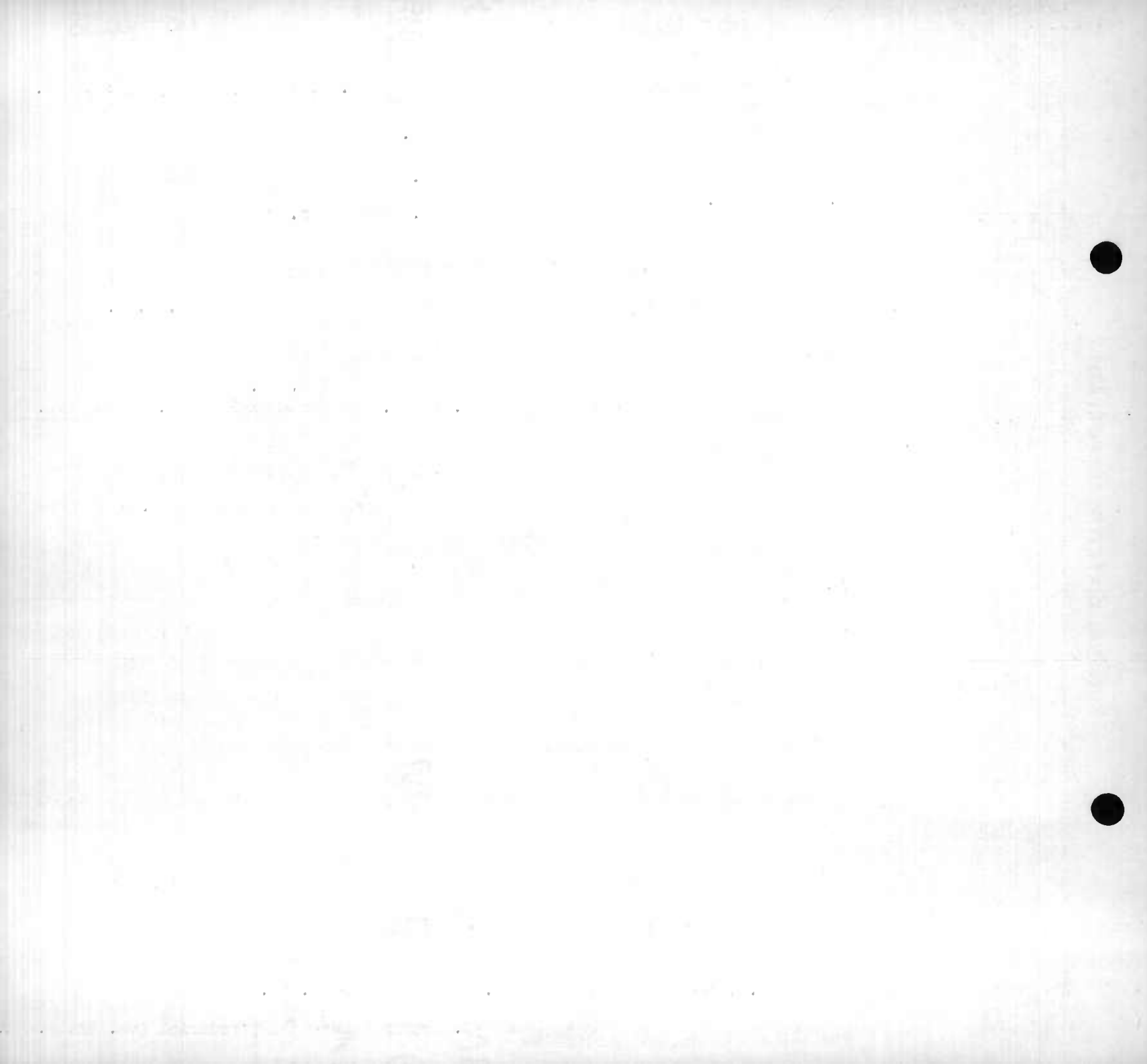
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DOROTHY KELLY		9-7-68 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL				A. STATE MARYLAND	
				B. COUNTY BALTIMORE Co.	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER Villa Maria	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-6-05	
				9. AGE (In years lost birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Mother		10B. KIND OF BUSINESS OR INDUSTRY Children Home		11. BIRTHPLACE (State or foreign country) IRELAND	
13. FATHER'S NAME RICHARD BYRNE				14. MOTHER'S MAIDEN NAME CATHERINE DAVIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-42-0648	
				17. INFORMANT Jim Kelly	
				ADDRESS 5629 Chelmsford Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 4201 II metastatic bronchial Ca				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mont.	
19A. DATE OF OPERATION 9/4		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED R pneumonectomy of lobes		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 7/18 1968 to 9/7 1968, that (I) (we) lost saw the deceased alive on 9/7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ed Barry Alperstein				23B. DATE SIGNED 9/8/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-68		24C. NAME OF CEMETERY or CREMATORY Dean's Grange Cemetery	
				24D. LOCATION (City, town, or county) (State) Co. Dublin IRELAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Chas. T. Evans	
				ADDRESS 8802 Theford Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9198	
1. NAME OF DECEASED (Type or Print) Henry Luedemann			2. DATE AND HOUR OF DEATH Sept. 6, 1968 12:05 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 245 S. Loudon Ave.			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> E. STREET AND NUMBER 245 S. Loudon Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 11, 1896	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10B. KIND OF BUSINESS OR INDUSTRY Cemetery	11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-1010A	17. INFORMANT Balto. Md. 21229 Mrs. Eva F. Luedemann 245 245 S. Loudon Ave.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Cronary Occlusion Cardio Vascular Disease & Coronary Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden June 1967	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 9/3/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/9 19 62 to 9/6 19 68 , that (I) (we) last saw the deceased alive on 9/3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edith W. Johnson M.D.				23B. DATE SIGNED 9/7/68	
23C. PHYSICIAN'S NAME (Type) Edith W. Johnson M.D.				23D. ADDRESS 3432 Frederick Ave. Balto. Md. NW 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Sept. 9, 1968	24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR G. Truman Schwab	
ADDRESS 3512 Frederick Ave. Balto. Md.					



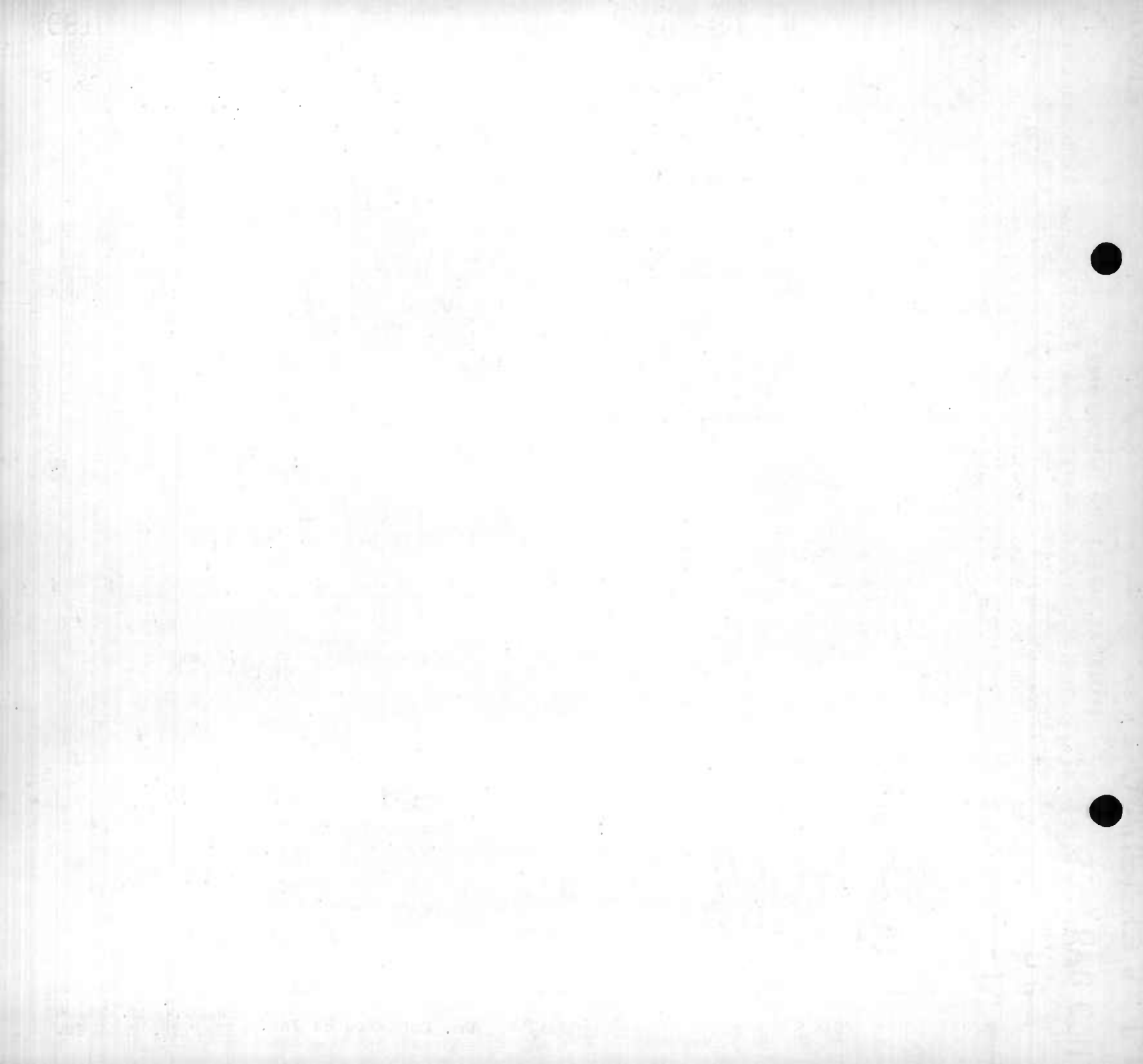
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9199 CERTIFICATE OF DEATH

REG. NO. 68- 9199

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Harley, Irene		2. DATE AND HOUR OF DEATH 9/7/68 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 12-01		
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2/19/91	
13. FATHER'S NAME Gustav Obendorfer		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 77	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 129-30-9142		11. BIRTHPLACE (State or foreign country) New York	
17. INFORMANT		12. CITIZEN OF WHAT COUNTRY? USA			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		(C) _____			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERVIFYING CAUSES OF DEATH? No.	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from 9/7/68 to 9/7/68 , that (I) (we) last saw the deceased alive on 9/7/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE Stuart V. Grandis, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/7/68	
23C. PHYSICIAN'S NAME (Type) Stuart V. Grandis, M.D.		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-68		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Bronx		City, town, or county (State) New York			
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.	
				ADDRESS Balto., Md. 21204 1217 St. Paul St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9200 CERTIFICATE OF DEATH

Baltimore City Health Department

REG. NO.

68- 9200

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROSS C. HORN BAKER		2. DATE AND HOUR OF DEATH Sept. 6, 1968 10:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home Hospital			A. STATE Maryland B. COUNTY Carroll		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Sykesville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER Re. 2, Box 49		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1929	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) practical nurse			10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Sykesville, MD
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME BROWN Hornbaker		
14. MOTHER'S MAIDEN NAME Myrtie CONAWAY			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		
16. SOCIAL SECURITY NO. 213-18-8012			17. INFORMANT Ruby Hornbaker		
18. ADDRESS Re. 2 Box 49 Sykesville Md			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>I 410.9</p> <p>CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarct</p> <p>(B) E Cardiogenic shock and Acute Pulmonary Edema</p> <p>(C) _____</p>					
<p>II 420.1</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Sept. 5 19 68 to Sept. 6 19 68 , that (I) (we) last saw the deceased alive on Sept. 6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Corazon Z. Vergara, M.D.				23B. DATE SIGNED Sept. 6, 1968	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.				23D. ADDRESS Church Home Hospital, 100 N. Broadway	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/1968		24C. NAME OF CEMETERY or CREMATORY Evergreen Mem. Gardens Finksburg, Carroll, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.			

for W. W. E.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.
W. W. E. & Co.
W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

W. W. E. & Co.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9201 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9201

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John Charles Frederick Sohn</i>		2. DATE AND HOUR OF DEATH <i>9-5-68 1:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>-</i>		C. CITY OR TOWN <i>BALTO.</i> D. INSIDE CITY LIMITS? <i>26</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>3209 E. BALTO. ST</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/28/91</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>CHARLES P. SOHN</i>		14. MOTHER'S MAIDEN NAME <i>BARBARA HOERL</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>UNK</i>		16. SOCIAL SECURITY NO. <i>217-05-8932</i>		17. INFORMANT <i>GENEVIEVE THOMPSON</i>	
18. <i>199.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Generalized Ca.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>199.2 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/26/68</i> 19 <i>68</i> to <i>9/5/</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>9/5</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jazayery</i>		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>JAZAYERY</i>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9/9/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>OAK LAWN</i>	
24D. LOCATION <i>BALTO. MD.</i>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 10 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>J.G. CONNELLY SONS</i>	
ADDRESS <i>300 MACE</i>					

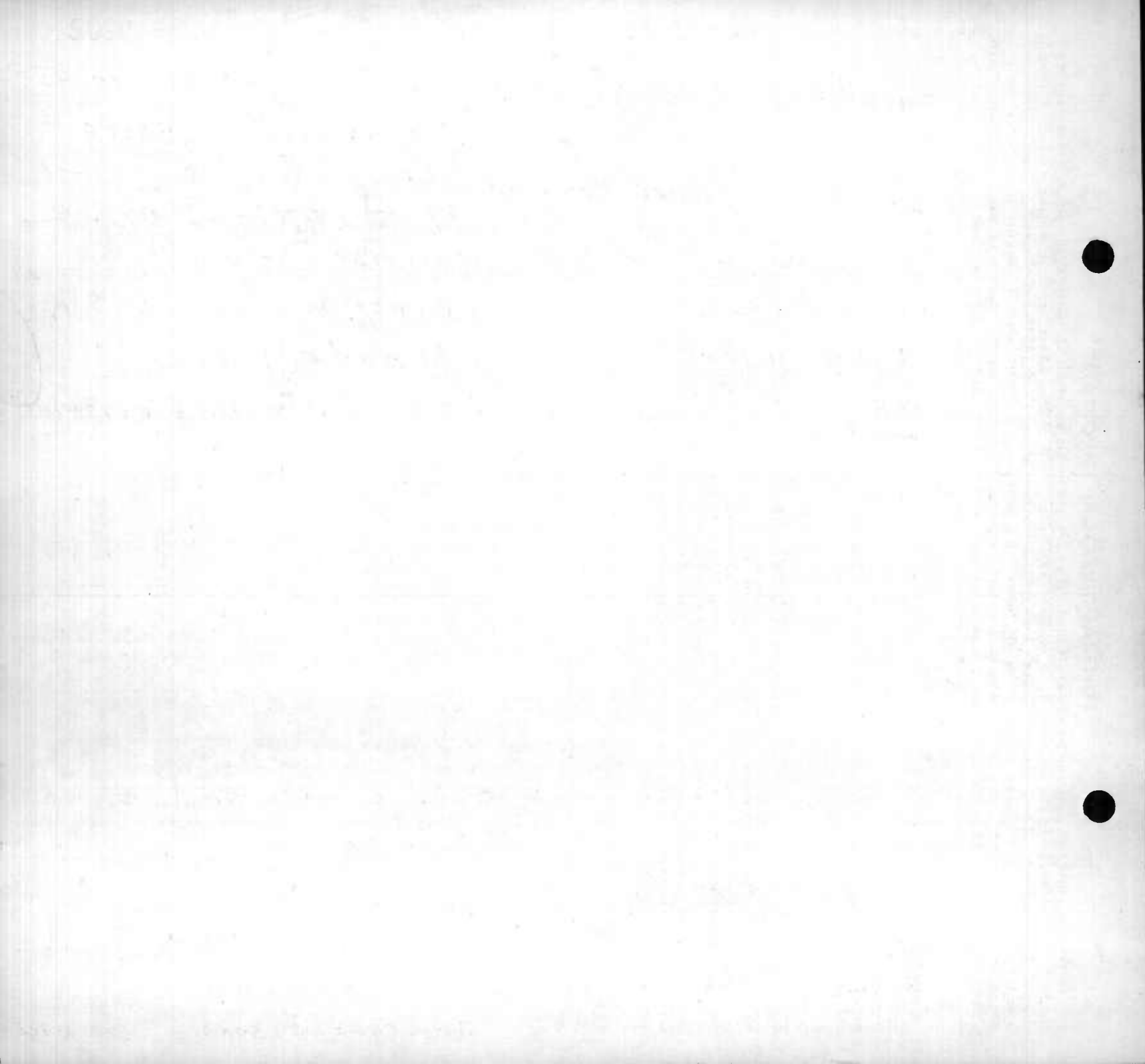
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9202 CERTIFICATE OF DEATH

REG. NO. 68- 9202

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wolfe, Virginia Maguerite</i>		2. DATE AND HOUR OF DEATH <i>9-5-68 10:45 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BALT 053-00</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Victory Villa</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>10-13-1910</i> 9. AGE (in years, last birthday) <i>57</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Wood</i>	
14. MOTHER'S MAIDEN NAME <i>Maudie Mae</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or Unknown) (If yes, give war or dates of service) <i>UNK</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William Wolfe, 126 Riverthorn Rd</i>		ADDRESS			
18. <i>437.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Arrest</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 5 1968</i> to <i>Sept. 5 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept. 5 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hyung K. Lee, M.D.</i>		23B. DATE SIGNED <i>Sept. 6, 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>Hyung K. Lee, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9/9/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>MORELANDS</i>	
24D. LOCATION <i>BALTO. MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 10 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Tarkenton</i>	
25C. FUNERAL DIRECTOR <i>J.G. CONNELLY SONS</i>		ADDRESS <i>300 MACE</i>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9203

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ROBERT J. MARCH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 6, 1968 8:25 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year September 6, 1968 8:25 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-6-1923		10. AGE (In years lost birthday) 45	
11. BIRTHPLACE (State or foreign country) Altoona, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quailty Control		14B. KIND OF BUSINESS OR INDUSTRY Westinghouse	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.11		17. SOCIAL SECURITY NO. 220-12-5056	
15. MOTHER'S MAIDEN NAME Edna Burkhardt		18. INFORMANT Mrs Evelyn L. March	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-10-1968	
24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
25A. DATE RECEIVED BY HEALTH DEPT SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton	
25C. FUNERAL DIRECTOR 7401 Belair Road		ADDRESS 7401 Belair Road Baltimore, Md	

X

WALLLEY POLICE

REPORT

FILE

WALLLEY POLICE

68- 9204

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9204

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JENNIE BURNS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 6, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 6, 1968 M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-19		C. CITY OR TOWN Baltimore	
6. SEX Female		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Oct. 31, 1899		10. AGE (In years last birthday) 68 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BALTO. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Burns		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
15. MOTHER'S MAIDEN NAME Anna Murphy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 215-01-9459		18. INFORMANT Bernadine Burns - 5716 Key Avenue	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9-10-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Edward F. Wilson, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 7, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-10-68	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		ADDRESS	

62-133

62-133

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

1
J-525

68- 9205 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9205

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MADALENE

JOHNSON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

September 7, 1968

9:15 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 7, 1968

9:15 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Female

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

Sept 1, 1901

10. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1638 Hazel Avenue

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Gabriel

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary O'Brightis

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Nellie Milewski 1638 Hazel St 21226

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Hypertensive Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes Mellitus

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type) Edward F. Wilson, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 8, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/12/68

24C. NAME of CEMETERY or CREMATORY

Meadowridge Mem Pk

24D. LOCATION (City, town, or county)

Elkridge Howard Co

(State)

Md

25A. DATE REC'D BY HEALTH DEPT

SEP 10 1968

25B. NAME OF REGISTRAR

Robert E. Seabury

25C. FUNERAL DIRECTOR

Mc Carthy F.H. 737 fctopsea ave

ADDRESS

10-10-50

10-10-50

10-10-50
10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

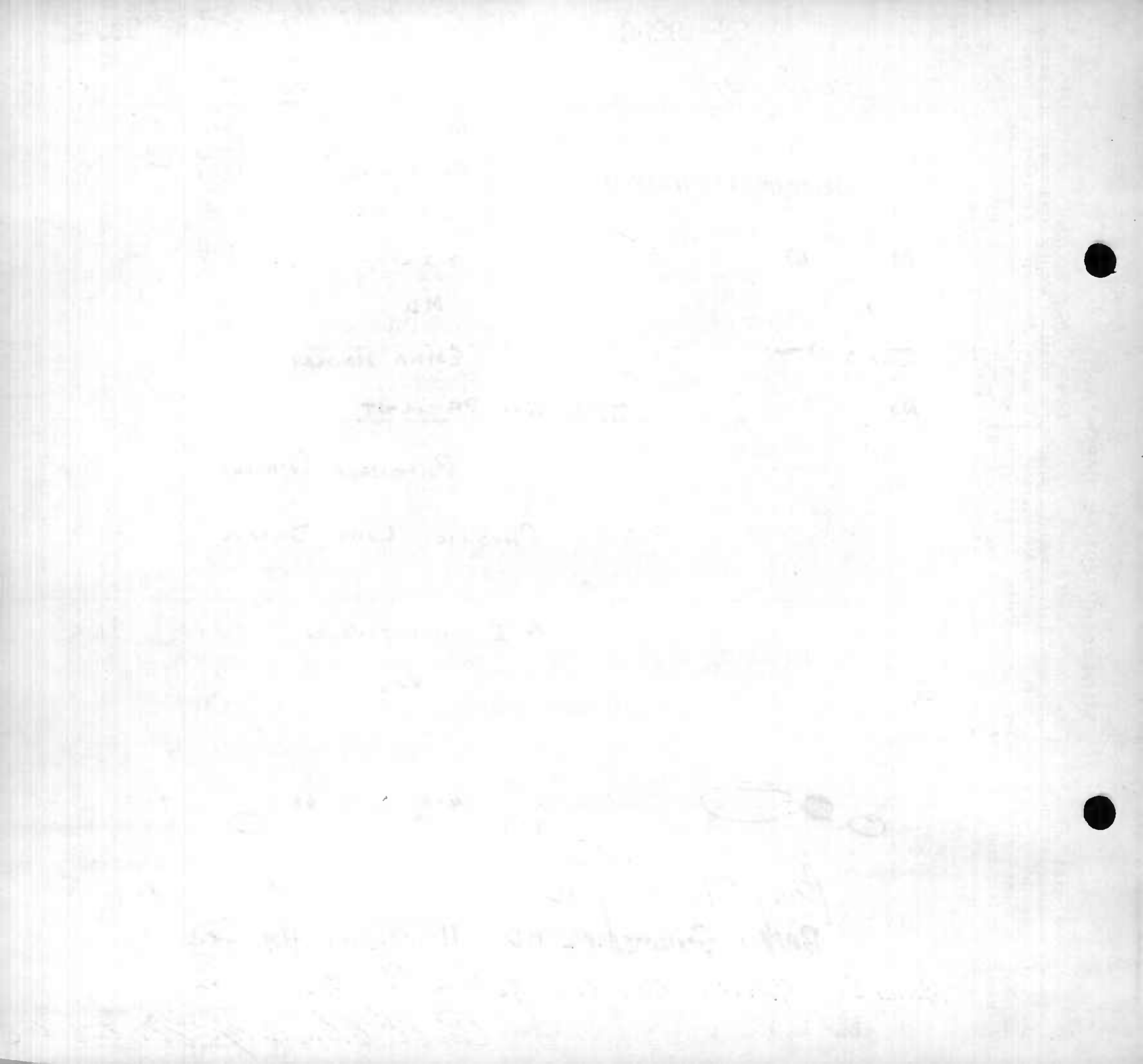
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9206 CERTIFICATE OF DEATH

REG. NO. 68- 9206

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>WILLIAM OTTO</u>		2. DATE AND HOUR OF DEATH <u>Sept. 7, 1968</u> <u>8:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3122 KESWICK RD.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-12</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>JOHN OTTO</u>		14. MOTHER'S MAIDEN NAME <u>EMMA MOWERY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-05-4661</u>		17. INFORMANT <u>PATIENT.</u>	
18. <u>519.2</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EMBOLUS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHRONIC LUNG DISEASE</u> (B) <u>5 YRS.</u> (C) <u>527.2 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>G.I. HEMORRAGE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Wk</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-1</u> <u>1968</u> to <u>9-7</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>9-7</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barry Schlossberg MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-7-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>BARRY SCHLOSSBERG MD</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/10/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mount Vernon M.C.</u>		24D. LOCATION (City, town, or county) (State) <u>Harward Co</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Farley, MA</u>	25C. FUNERAL DIRECTOR <u>Paul C. Chennault</u>		ADDRESS <u>3615</u>	



REG. NO.

VS 151-REV. 1/1/68

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **68- 9208**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LAVERNE PRINCE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 7, 1968 9:00 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year September 7, 1968 9:00 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH Aug. 15, 1939		10. AGE (In years lost birthday) 29 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Darlington S.C.		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement finisher		14B. KIND OF BUSINESS OR INDUSTRY Construction	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Clifton Prince		15. MOTHER'S MAIDEN NAME Corrine Ross	
18. INFORMANT Cesar Prince		ADDRESS 1706 Milton Ave.	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hanging (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 712 N. Carrollton Street		22F. HOW DID INJURY OCCUR? Subject hanged himself	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) Sept. 7, 1968 8:22 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED September 8, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/68	
24C. NAME OF CEMETERY or CREMATORY Lanston Grove Cem.		24D. LOCATION (City, town, or county) (State) Darlington S.C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Sub E. Jackson	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3971 Schwab	

Curial P. Williams & Co. Architects & C.
William P. Williams & Co. Architects & C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9209 CERTIFICATE OF DEATH

REG. NO. 68- 9209

BIRTH NO.		1. NAME OF DECEASED (Type or Print) DEGENHARD, GEORGE LOUIS		2. DATE AND HOUR OF DEATH September 9, 1968 2:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Baltimore INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		E. STREET AND NUMBER 134 N. Linwood Ave.			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-1894	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Research		10B. KIND OF BUSINESS OR INDUSTRY Naval Research Lab.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Degenhard		14. MOTHER'S MAIDEN NAME Mollie Gray	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5-7-17 to 1-2-19		16. SOCIAL SECURITY NO. 213-20-8111		17. INFORMANT Records ADDRESS V. A. Hospital, Baltimore, Maryland 21218	
18. 412.514202.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary thromboemboli, massive, bilateral ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis, generalized, marked especially of coronary arteries, with more than 90% stenosis, bilateral Mycosis fungoides of skin		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April 23, 1968 to September 9, 1968 , that (I) (we) last saw the deceased alive on September 9, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) V. A. Hospital, 3900 Loch Raven Blvd. Baltimore, Md. 21218	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968	
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR John A. Moran, Inc.		25D. ADDRESS 3000 E. Baltimore St	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9210

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PHILLIP VANSTEINBURG		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 4, 1968 4:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour September 4, 1968 4:00 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Brunswick	
9. DATE OF BIRTH November 28, 1913		10. AGE (In years lost birthday) 24 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police officer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 163-72-2187	
15. MOTHER'S MAIDEN NAME Ida Fisher		18. INFORMANT Mrs. Ida Fisher Van Steinburg	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E816X		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro-cranial injuries DUE TO, OR AS A CONSEQUENCE OF: (b) _____ (c) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) woods	
22D. TIME OF INJURY (APPROX.) 8-31-68 2:00 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) #464 - Intersection of Point Rock Road		22F. HOW DID INJURY OCCUR? Driver of police car that ran off road while chasing another auto	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) Yes	
ACTUAL SIGNATURE Charles S. Springate, M.D.		DATE SIGNED September 5, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/7/68	
24C. NAME OF CEMETERY or CREMATORY Hillsboro Cemetery		24D. LOCATION (City, town, or county) (State) Hillsboro Virginia	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Feete Funeral Home, Brunswick, Md.		ADDRESS	

14

INTERNATIONAL RIGHTS

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

MAILED

027.220

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9211	
BIRTH NO. 68- 9211		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type in full) RAVENSCROFT, MARGARET AGNES		2. DATE AND HOUR OF DEATH SEPTEMBER 9, 1968 4:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS AND CATON AVENUE BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 21228 Balto Co 53-00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1403 ADAMS VIEW ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07 12 96 9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MICHAEL J. FINAN	
14. MOTHER'S MAIDEN NAME (REED) MARGARET		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 215320521		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.3 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia (B) <i>Ca of sigmoid colon</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 153.3 II	
20A. DATE OF OPERATION D		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (XX) (this hospital) attended the deceased from AUGUST 19, 1968 to SEPTEMBER 9, 1968, that (XX) (we) last saw the deceased alive on SEPTEMBER 9, 1968, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.			
23A. SIGNATURE Ruben V. Luna		23B. DATE SIGNED 09 09 68	
23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNA		23D. ADDRESS BALTIMORE MARYLAND ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-11-68	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE RECEIVED BY HEALTH DEPT. SEP 10 1968	25B. NAME OF REGISTRAR Ruben E. Luna	25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave 21229	

1158-63

RECEIVED

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

1
0-163

68- 9212

BALTIMORE CITY HEALTH DEPARTMENT

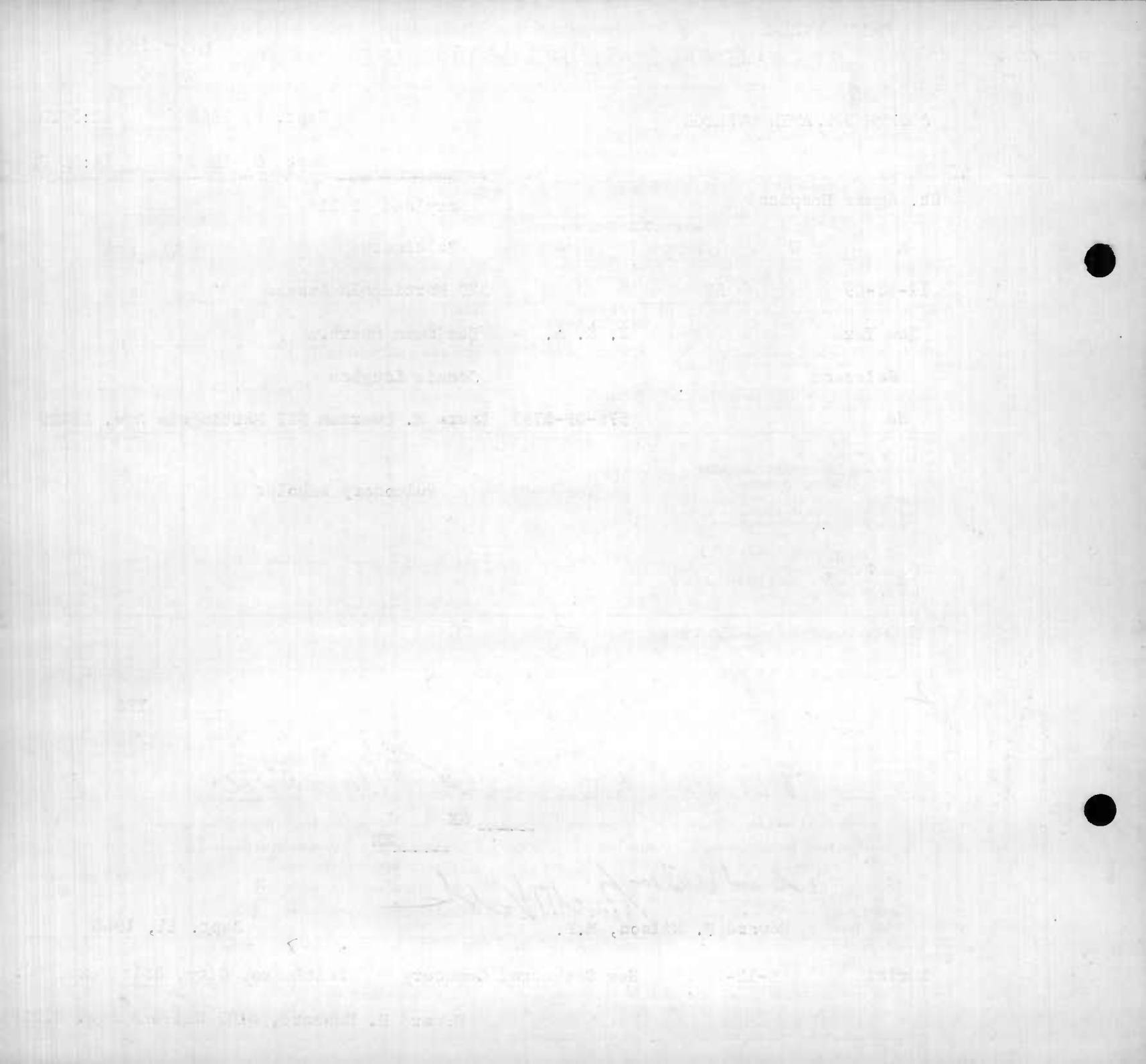
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9212

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH BENJAMIN OVERTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Sept. 8, 1968 Hour 11:50PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour Sept 8, 1968 11:50 PM	
6. SEX M		7. RACE W	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11-18-09		10. AGE (In years lost birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 578-09-8793	
13. FATHER'S NAME Benjamin Overton		15. MOTHER'S MAIDEN NAME Jennie Laughan	
18. INFORMANT Laura M. Overton		ADDRESS 327 Martingale Ave. 21229	
19. E 968 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of femur	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 327 Martingale Ave 21229		22D. TIME OF INJURY (APPROX.) 7 8 68 8:30 PM	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Assaulted	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Edward F. Wilson, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Sept. 11, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-68	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, City, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1968		25B. NAME OF REGISTRAR Robert E. Farley, Jr.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9213
BIRTH NO.		68- 9213 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) MARY C. Wehn		2. DATE AND HOUR OF DEATH 9/8/68 605 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Anne Arundel 52-00		
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND General Hospital		C. CITY OR TOWN Linthicum D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 223 Poplar Ave		
5. SEX FEMALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/92	9. AGE (In years lost birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife		10B. KIND OF BUSINESS OR INDUSTRY OWN Home		11. BIRTHPLACE (State or foreign country) PA. [New Freedom]
12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME [UNKNOWN] - Butcher		14. MOTHER'S MAIDEN NAME [UNKNOWN]		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT (son) 108 Second ave Ferndale, Md.
18. 4412 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ABDOMINAL AORTIC Aneurysm Ruptured		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hr.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC E-V Disease				
19. 451X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0 -	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that the (this hospital) attended the deceased from 9/4/68 19 to 9/8/68 19, that (I) lost last saw the deceased alive on 9/8/68 19 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.				
23A. SIGNATURE C. Thomas Flotte M.D.				23B. DATE SIGNED 9/8/68
23C. PHYSICIAN'S NAME (Type) C. THOMAS FLOTTE, M.D.				23D. ADDRESS 827 LINDEN Ave., BALTIMORE, Md. 21201
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-11-68	24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE MEM. PK ELKridge, R.F.D. Md.		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968	25B. NAME OF REGISTRAR Robert E. Jackson	25C. FUNERAL DIRECTOR SINGLETON FUNERAL HOME Glen Burnie, Md.		

CONFIDENTIAL
This document
is classified

20

[The following]

[UNKNOWN]

Warrant for the arrest of
George J. [Name]

Handwritten - own name

[Signature]

NO MORE

Don't 9-11-68 [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

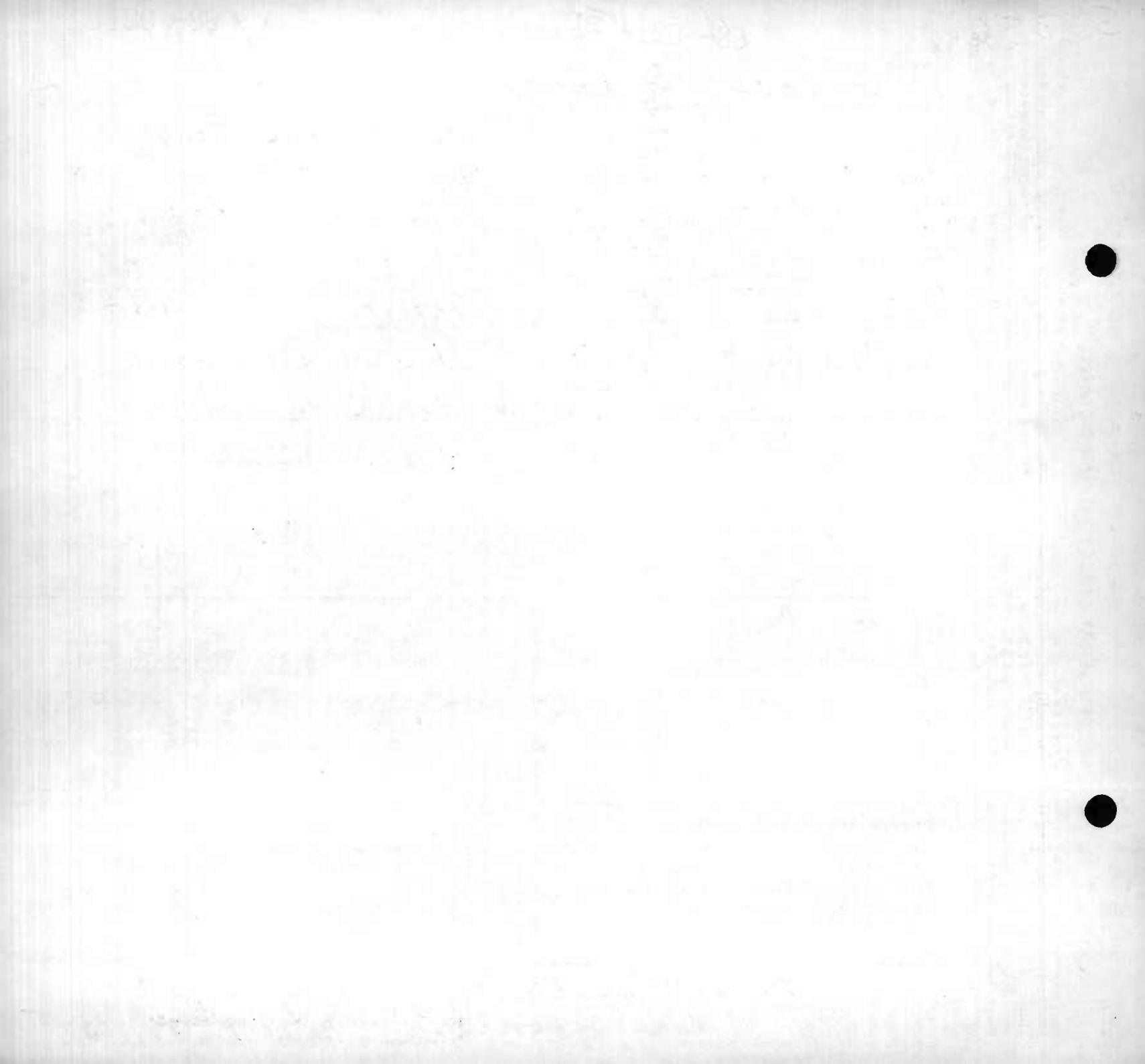
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9214 CERTIFICATE OF DEATH

REG. NO. 68- 9214

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GENEVA SYDNOR		2. DATE AND HOUR OF DEATH 9-8-1968 1 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY Richmond County		C. CITY OR TOWN Warsaw, Va. 22572 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital, Inc. 39 Division St. Baltimore, Md 21217		E. STREET AND NUMBER Route # 3		V-43	
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-1906	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Shelton		14. MOTHER'S MAIDEN NAME Lucy Diamond	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 223-40-3866		17. INFORMANT Herman Sydnor	
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized Metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Coronary Artery Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Generalized Metastasis (B) DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
173.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herman Sydnor		23B. DATE SIGNED 9-8-68		23C. PHYSICIAN'S NAME (Type) DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-11-68		24C. NAME OF CEMETERY or CREMATORY Mountain Baptist Church	
24D. LOCATION (City, town, or county) (State) Downing, Virginia		25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Funeral Home, King's Highway, 22485		25D. ADDRESS Frederick W. Scarborough Road #146			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9215

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRY FREIDMAN Aka FRIEDMAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 3 68 12:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 60816 Park Ave.		3. DATE PRONOUNCED DEAD Month Day Year September 3, 1968 12:45 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9-13-1910		10. AGE (In years, lost birthday) 57 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Abram Friedman		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		14B. KIND OF BUSINESS OR INDUSTRY Stationery	
15. MOTHER'S MAIDEN NAME Fanny Schiffnagel		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes WW II Unk.	
17. SOCIAL SECURITY NO. 083 10 0129		18. INFORMANT 3907 Longstreet Court Mollie Rosen Annadale Va.	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. DATE SIGNED September 4, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 9, 68	
24C. NAME of CEMETERY or CREMATORY King David Memorial Garden		24D. LOCATION (City, town, or county) (State) Fallschurch, Va.	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Goldberg Fun'l Home		ADDRESS 4217 9th St. N.W. Wash. D.C 20011	

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9216 CERTIFICATE OF DEATH

REG. NO. **68- 9216**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Jackson, Charles Rufus		2. DATE AND HOUR OF DEATH September 6, 1968 5:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 23 3900 Loch Raven Blvd. Baltimore, Maryland 21218				A. STATE District Of Columbia V-48 B. COUNTY C. CITY OR TOWN Washington D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 701 Longfellow St., Northwest	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/88	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? United States			13. FATHER'S NAME Jerry Jackson		
14. MOTHER'S MAIDEN NAME Edmonia Brown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/23/18-7/28/19		
16. SOCIAL SECURITY NO. 578-54-23-76			17. INFORMANT Veterans Hospital Records ADDRESS Baltimore, Maryland 21218		
18. 157.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Renal Failure-Secondary to DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma Of The Pancreas DUE TO, OR AS A CONSEQUENCE OF: (C) ...					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 1 Year
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from August 7, 1968 to September 6, 1968 that (H) (we) last saw the deceased alive on September 6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald C. Elkins MD				23B. DATE SIGNED 9/7/68	
23C. PHYSICIAN'S NAME (Type) Ronald C. Elkins MD.				23D. ADDRESS Veterans Administration Hosp., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9.11.68	24C. NAME OF CEMETERY OR CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Ludlow Carrols, 1529 East North Ave, Balto.	

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "through" and "the" are faintly visible.]

Bank of Montreal 11/11/19

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9217

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES WILLIAMS

2. DATE
OF
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

UNK

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August 19, 1968

9:30 A.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland

B. COUNTY

Pental Ct. (alley) rear 900 Penna. Ave.

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS

YES ☒NO ☐

9. DATE OF BIRTH

NOV. 8, 1926

10. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1516 LINDEN AVE.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Advanced Decomposition. No Cause of

(A) IMMEDIATE CAUSE

~~Death Determined at Autopsy. No evidence of injury.~~Death Determined at Autopsy. No evi-
dence of injury.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

795.3

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/19/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

9/10/68

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 11 1968

Robert E. Fairbanks

MORTUARY SERVICE - BCHD

امیدوارم در خدمت

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9218

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LESTER S. NEILSON

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

8

22

68

2:40 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August

22

1968

2:40 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☐NO ☐

6. SEX

Male

7. RACE

White

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1024 S. Charles St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. 5-7-1-9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cirrhosis of the liver
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

9/9/68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

ADDRESS

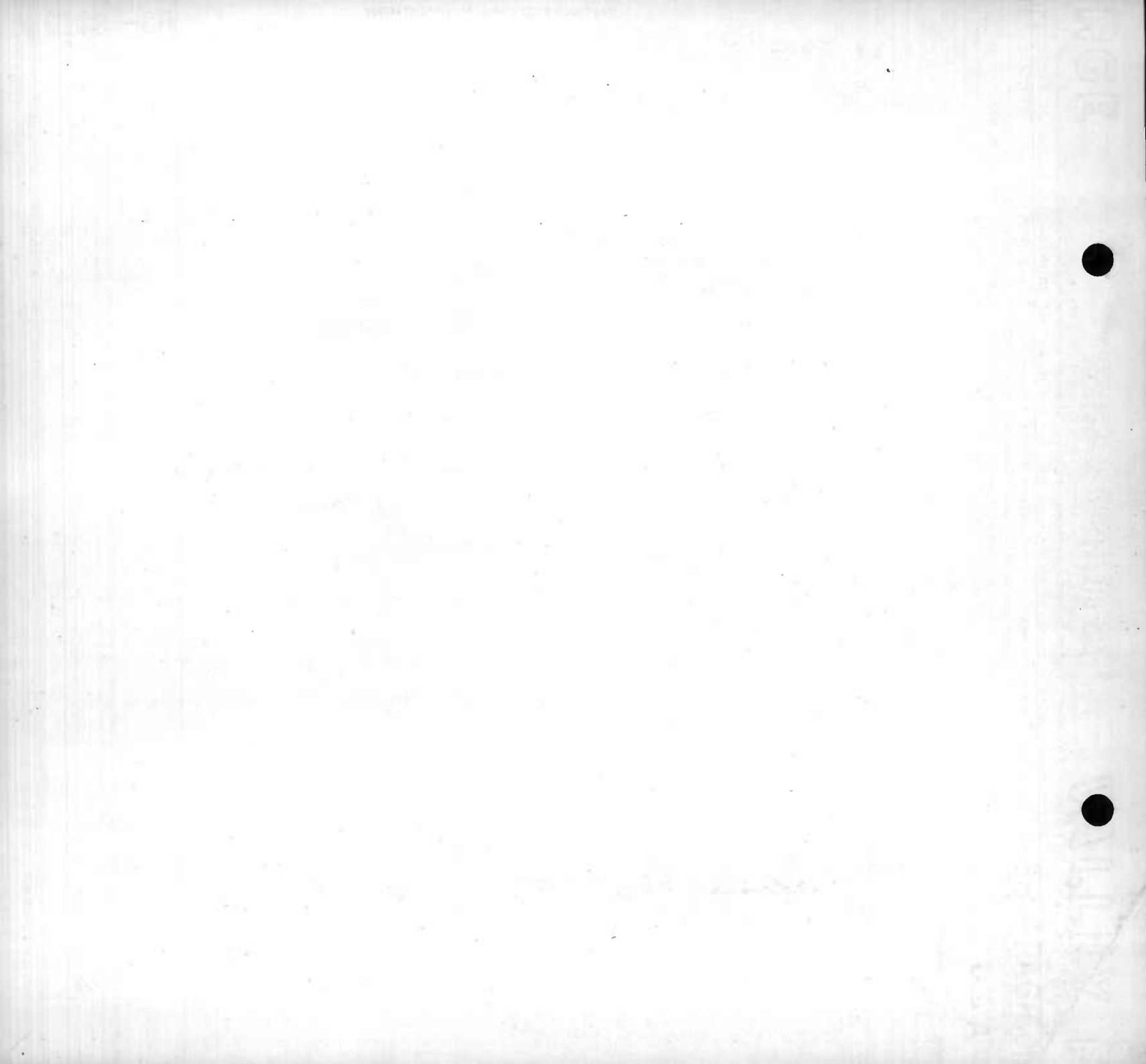
MORTUARY SERVICE - BCHD

WALTER H. BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68- 9219 y
BIRTH NO. 68-15493		68- 9219		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary Ann Green			2. DATE AND HOUR OF DEATH Aug 17, 1968 5:15 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN 21227 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 12 N. Twin Circle		
5. SEX F	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17, 1968	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 5 min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME James William Green			14. MOTHER'S MAIDEN NAME Barbara Leona Cox		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother ADDRESS Same	
18. 770.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic obstructive pulmonary (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
MEDICAL CERTIFICATION 761.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome Fleet MD			23B. DATE SIGNED Aug 18, 1968		
23C. PHYSICIAN'S NAME (Type) JEROME FLEET, MD			23D. ADDRESS Lutheran Hospital of Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 8-29-68		24C. NAME OF CEMETERY or CREMATORY Heath Dept.	
24D. LOCATION Balto.		24E. LOCATION (City, town, or county)		24F. LOCATION (State) Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9220
T-651		68- 9220		9
BIRTH NO. 68-15445		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Turner Baby boy</i>		2. DATE AND HOUR OF DEATH <i>1:45 AM Aug 16 1968 M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hospital of Maryland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Balto</i> C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>3320 Prestonan St, Apt A-6</i>		
5. SEX <i>Male</i>	6. RACE <i>negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14 1968</i>	9. AGE (In years last birthday) <i>1</i> Yr. <i>1</i> Mo. <i>15</i> Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Lutheran Hospital</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Theodore M</i>		
14. MOTHER'S MAIDEN NAME <i>Christine T. BROWN</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart</i>		
18. <i>772.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Brain Hypoxia due to Brain Edema and possible Premature Brain Hemorrhage and Massive compressed syndrome</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>From 11:30 AM Aug 14-68 To 1:45 AM Aug 16-68 (39 hrs)</i>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>768.5 II</i>				
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 14 1968</i> to <i>Aug 16 1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Sg Huh mo</i>		23B. DATE SIGNED <i>8/16/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Soung Yoon Huh</i>
23D. ADDRESS <i>Lutheran Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremated</i>		
24B. DATE <i>8-19-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Medical EXAMINERS OFFICE Balto.</i>		24D. LOCATION (City, town, or county) (State) <i>Md.</i>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 92217
BIRTH NO. 68-15444		68- 9221		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BAJBY BOY SODEN			2. DATE AND HOUR OF DEATH Aug. 16, 1968 9:25 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 2846 W. NORTH AVENUE # 21216 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEP. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1968	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 16
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND, U.S.A.	
13. FATHER'S NAME Raymond Green			14. MOTHER'S MAIDEN NAME REGINA JOHNSON SODEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MOTHER - 2846 W. NORTH AVE. #16	
18. 742X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH CONGENITAL ANOMALY (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYDROCEPHALUS, MARKED (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION 752X II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
19C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Aug. 16 19 68 to Aug. 16 19 68 , that (I) (we) last saw the deceased alive on Aug. 16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Desideria T. Mahusay, M.D.			23B. DATE SIGNED Aug. 16, 1968		23C. PHYSICIAN'S NAME (Type) DESIDERIA T. MAHUSAY, M.D.
23D. ADDRESS LUTHERAN HOSPITAL			24A. BURIAL CREMATION, REMOVAL (Specify) CREMATED		
24B. DATE 8-19-68			24C. NAME OF CEMETERY or CREMATORY Medical Examiner's Office		
24D. LOCATION (City, town, or county) (State) BALTO. MD.			25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		
25B. NAME OF REGISTRAR Robert E. Taylor, MA			25C. FUNERAL DIRECTOR ADDRESS 9221		

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9222	
BIRTH NO. 68-16511		68- 9222		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BABY BOY WILNER			2. DATE AND HOUR OF DEATH September 3 1968 11:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE Where deceased lived. If institution, residence before admission) A. STATE Md B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME HOSPITAL			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Sept - 3, 1968		9. AGE (In years lost birthday) NB
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOSEPH WILNER			14. MOTHER'S MAIDEN NAME JOAN WILNER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT DR SAINI ADDRESS To Mother in Hospital.
18. 777X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. PREMATURITY (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. 776X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 3 1968 to Sept. 3 1968 , that (I) (we) last saw the deceased alive on Sept. 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Corazon Z. Vergara, M.D.				23B. DATE SIGNED Sept. 3, 1968	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.				23D. ADDRESS University Medical School	
24A. BURIAL CREMATION, REMOVAL (Specify) 9/6/68		24B. DATE 9/6/68		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BMD	

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

JOSEPH W. HICK

JOHN W. HICK

RECEIVED

JAN 2 1901

JOSEPH W. HICK

JOHN W. HICK

FUNERAL DIRECTOR: IMPORTANT

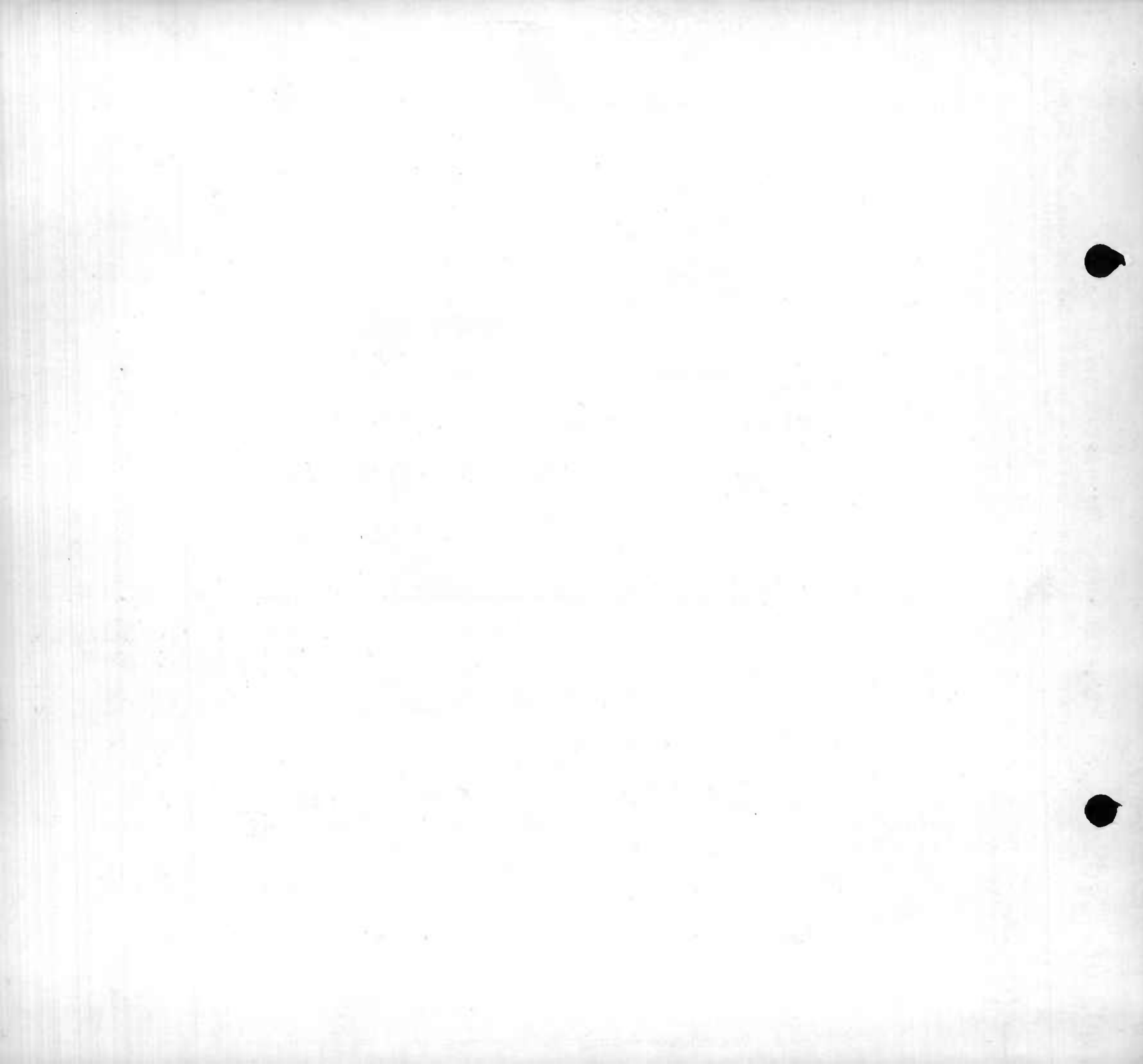
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9223

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 9223

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARL JERMIN		8/29/68 3:10 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University				A. STATE MD B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER NO ADDRESS 00-00	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-7-1905	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRANSIENT		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) S. DAKOTA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT PT ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				-	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				(B) ALCOHOLIC CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.				(C) -	
322.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CARDIAC ARRHYTHMIA	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/29/68 to 8/29/68, that (I) (we) lost saw the deceased alive on 8/29/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry Schlossberg MD				23B. DATE SIGNED 8/29/68	
23C. PHYSICIAN'S NAME (Type) BARRY SCHLOSSBERG MD				23D. ADDRESS HANAPONTY BOULEVARD OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) 9/6/68		24B. DATE 9/6/68		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		24E. MORTUARY SERVICE - BCHD			
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68- 9224	
BIRTH NO. <u>Whicomico Co. Md.</u> 68- 9224				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>DORSEY BABY GIRL</u>		2. DATE AND HOUR OF DEATH <u>8/14/68</u> <u>4:30 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Montgomery Co. 65-00</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSPITAL</u>		C. CITY OR TOWN <u>TACOMA PARK</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
38		E. STREET AND NUMBER <u>7713 HOLLY AVE.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/68</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months: <u>3</u> Days: <u>3</u> Hours: <u>3</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>WILLIAM DORSEY</u>		14. MOTHER'S MAIDEN NAME <u>CAROL ANN SHORTER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NA</u>		17. INFORMANT ADDRESS	
18. <u>741.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PROBABLE SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>RUPTURED MENINGIOMYELOCELE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>751X II</u>					
19A. DATE OF OPERATION <u>8/12/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>MENINGIOMYELOCELE</u>		20A. AUTOPSY (Yes or No) <u>2</u> <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> 19 <u>68</u> to <u>8/14</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/14</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John S. Ignatowski MD</u>		23B. DATE SIGNED <u>8/14/68</u>		23C. PHYSICIAN'S NAME (Type) <u>John S. Ignatowski MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/6/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>UNIVERSITY MEDICAL SCHOOL</u> <u>HOSPITAL DISPOSAL</u>	

1
G-200

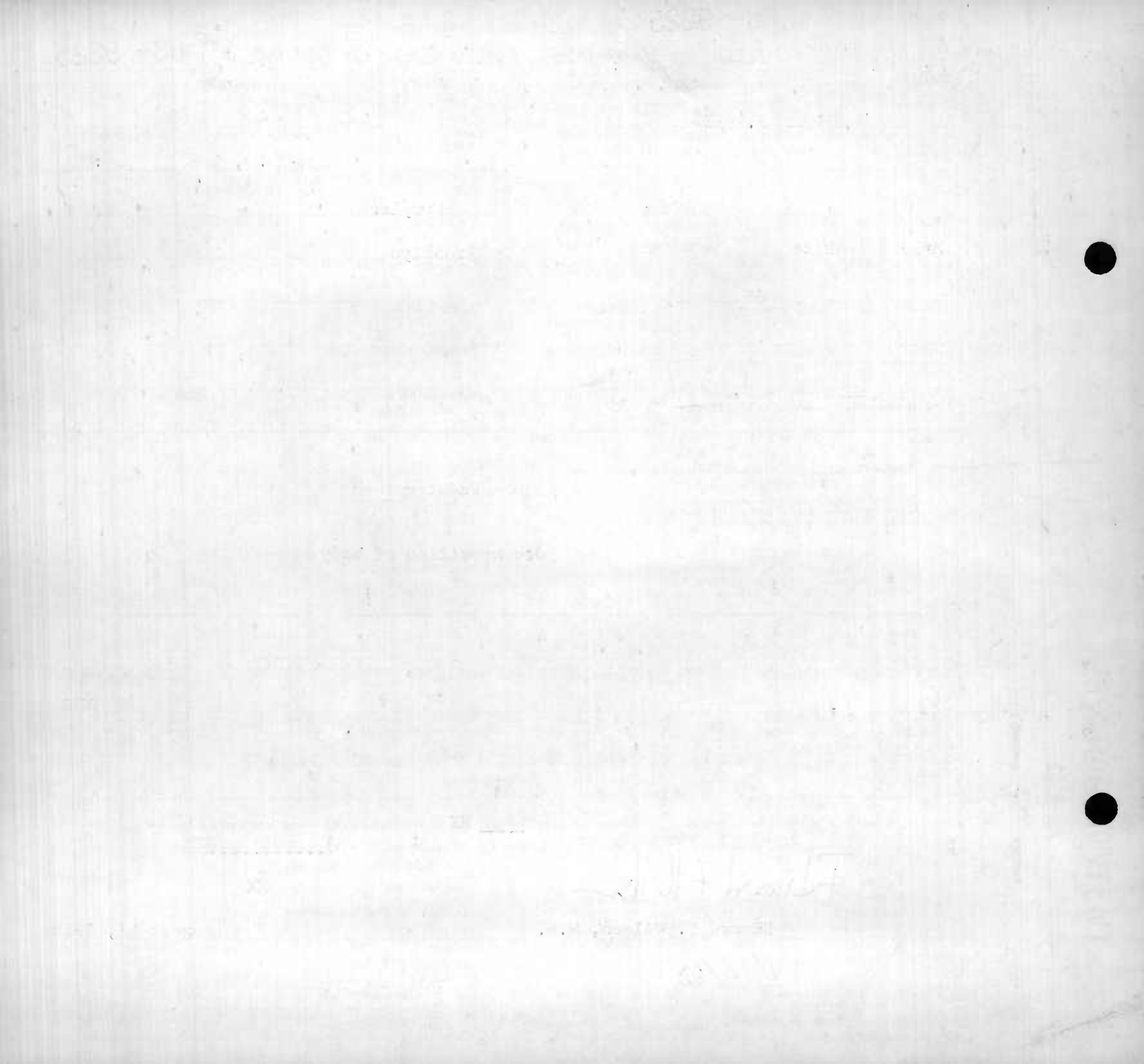
68- 9225 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9225

BIRTH NO.

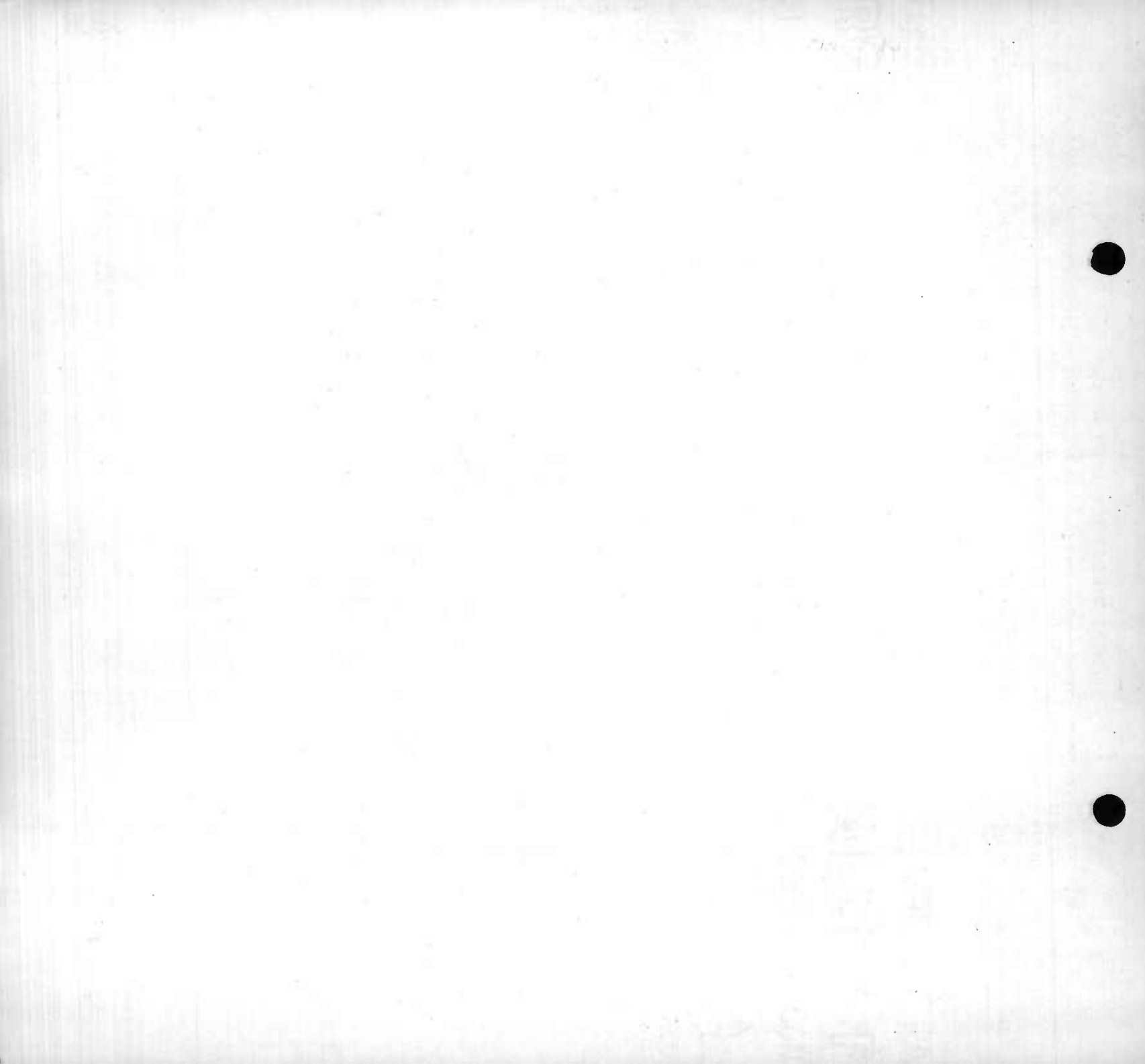
1. NAME OF DECEASED (Type or Print) EDWARD A. GEIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 8 20 68	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2203 Eutam Pl.		3. DATE PRONOUNCED DEAD Month Day Year Hour August 20, 1968 4:00 p.m.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Brooklyn	
9. DATE OF BIRTH 66		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 66		E. STREET AND NUMBER	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 796.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Undetermined (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: decomposition of body (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 21, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/10/68	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68- 9226
BIRTH NO. 68-16142		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Robert Lawrence Vaughan			2. DATE AND HOUR OF DEATH 8-25-68 17⁰⁰ P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Randallstown D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8602 Gray Fox Rd #21133		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-25-68	9. AGE (In years last birthday) 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert Harry Vaughan			14. MOTHER'S MAIDEN NAME Carol Ann Reter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Carol Ann Vaughan	
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Immaturity DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. 776X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-25 19 68 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Hesthaus, M.D. DEGREE				23B. DATE SIGNED 8/25/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 8-29-68		24C. NAME OF CEMETERY or CREMATORY Mt. Gen. Hosp.	
24D. LOCATION (City, town or county) (State) 827 Linden Ave Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Stachura	
25C. FUNERAL DIRECTOR ADDRESS		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9227 CERTIFICATE OF DEATH

REG. NO. 68- 9227

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENRIETTA W. JOHNSON		2. DATE AND HOUR OF DEATH SEPT. 5, 1968 1.45P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3137 N. CALVERT ST.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3137 N. CALVERT ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1897	9. AGE (In years lost birthday) 70YRS.	10. CITIZEN OF WHAT COUNTRY? If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MANAGER MD. CAS. CAFETERIA		10B. KIND OF BUSINESS OR INDUSTRY MD. CAS. CAFETERIA		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME WILLIAM COWANX WILCOX		14. MOTHER'S MAIDEN NAME FLORANCE WXXXXX COWAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-3588		17. INFORMANT RAYMOND E. JOHNSON ADDRESS 3137 N. CALVERT ST.	
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Advanced myocardial Disease Arteriosclerosis Hypertension		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Coronary occlusion Advanced myocardial Disease Arteriosclerosis Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs " " " "	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1945 to Sept 5 1968 , that (I) (we) last saw the deceased alive on Sept 5-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W H Woody		23B. DATE SIGNED 9-6-68		23C. PHYSICIAN'S NAME (Type) W H Woody	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/9/68		24C. NAME of CEMETERY or CREMATORY GREENMOUNT	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Tabor		25C. FUNERAL DIRECTOR H.W. NEARS & SON ADDRESS 805 N. CALVERT ST.	

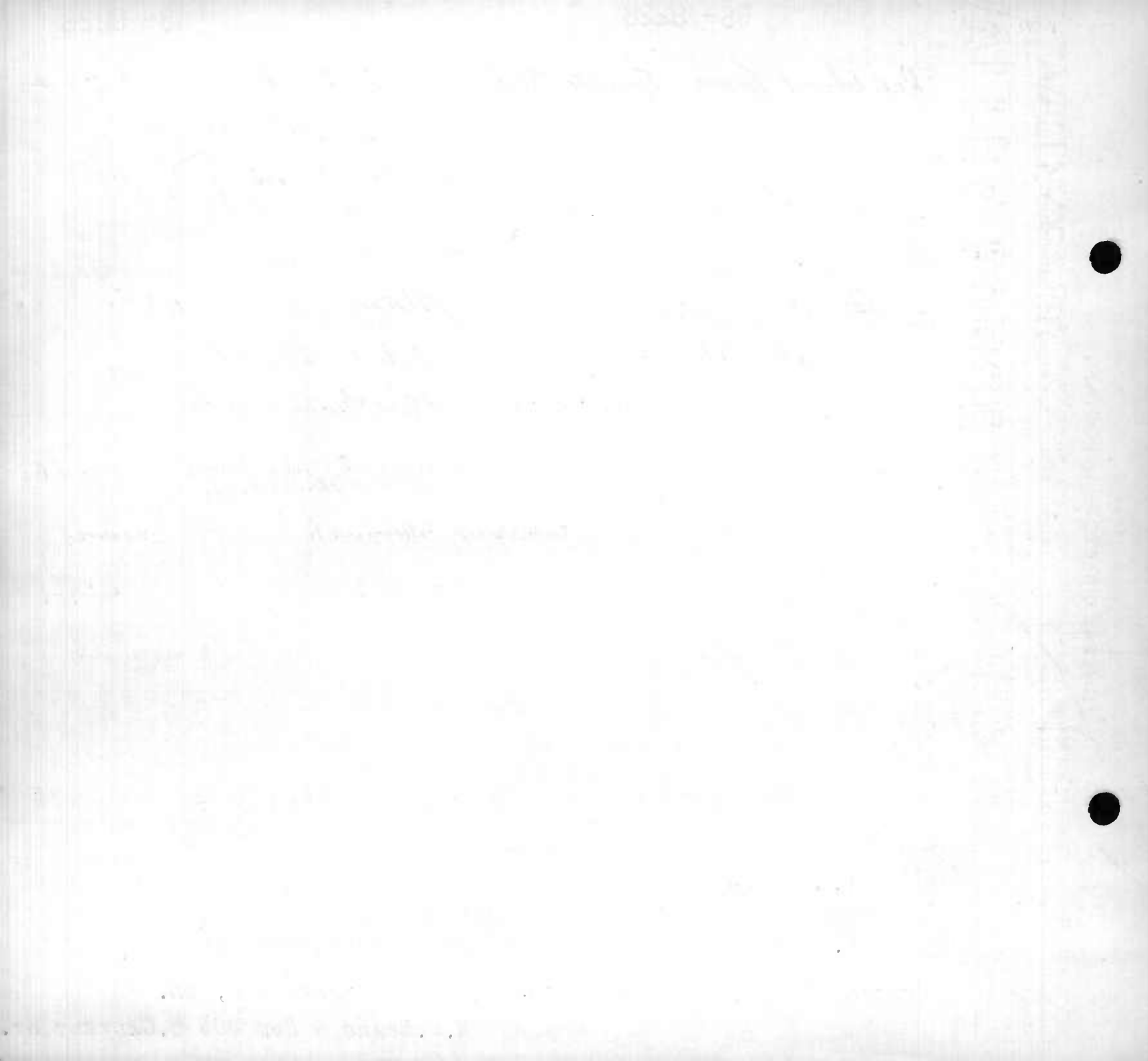
AAAAA

XXXXX

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9228
BIRTH NO.		1. NAME OF DECEASED (Type of ^{and} _{first}) <i>REV. Edward Thomas Farrell S.S.J.</i>		2. DATE AND HOUR OF DEATH <i>9. 8. 68 6.45 a.m.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>St Joseph's Manor.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>34</i> <i>Bon Secours Hospital, Balto. Md.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Catholic Priest</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>CLERGYMAN</i>		8. DATE OF BIRTH <i>12-21-99</i>
13. FATHER'S NAME <i>Robert M. Farrell</i>		14. MOTHER'S MAIDEN NAME <i>Edna Moran</i>		9. AGE (In years lost birthday) <i>68</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-52-9048</i>		11. BIRTHPLACE (State or foreign country) <i>MASS.</i>
17. INFORMANT <i>T Miss Donna Farrell</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
18. <i>1519 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <i>151X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Recurrent intestinal obstruction</i> (B) <i>Cancer of Stomach</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i> <i>years</i>
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>7. 28</i> 19 <i>68</i> to <i>9. 8</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9. 8</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>M. Keyhani</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9. 8. 1968</i>
23C. PHYSICIAN'S NAME (Type) <i>M. KEYHEENI</i>		23D. ADDRESS <i>BON SECOURS HOSPITAL</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9/10/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>CATHEDRAL</i>
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1968</i>		
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>H.W. MEARS & SON 805 N. CALVERT ST.</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9229
BIRTH NO.		68- 9229		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
thomas Pruitt		SEPT. 9, 1968 4:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
NORTH CHARLES (FED) Hosp.		Md. Baltimore 53-00		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
Repairman		Radio- Television		10-22-13
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)
William A. Pruitt		Willia Ann Greathouse		54
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)
NO		235-228755		W. Va.
17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?		
Flossie Pruitt		U.S.A.		
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Carcinoma lung with generalized metastasis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		(C) DUE TO, OR AS A CONSEQUENCE OF:
NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20A. AUTOPSY? (Yes or No)
				NO
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		(If in Baltimore City, give exact location)
22. I certify that (this hospital) attended the deceased from 9-9 19 68 to 9-9 19 68				
that (I) last saw the deceased alive on 9-9 19 68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Melencio Ventura		9-9-68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
DR. MELENICIO VENTURA		NORTH CHARLES (FED) HOSP		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial		9/12/68		Oak Lawn Cemetery
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
SEP 11 1968		Melencio Ventura		Bruzdinski
				ADDRESS
				Bruzdinski Funeral Home 1407 Eastern Ave.

10-2-10

10-2-10

10-2-10

10-2-10

10-2-10

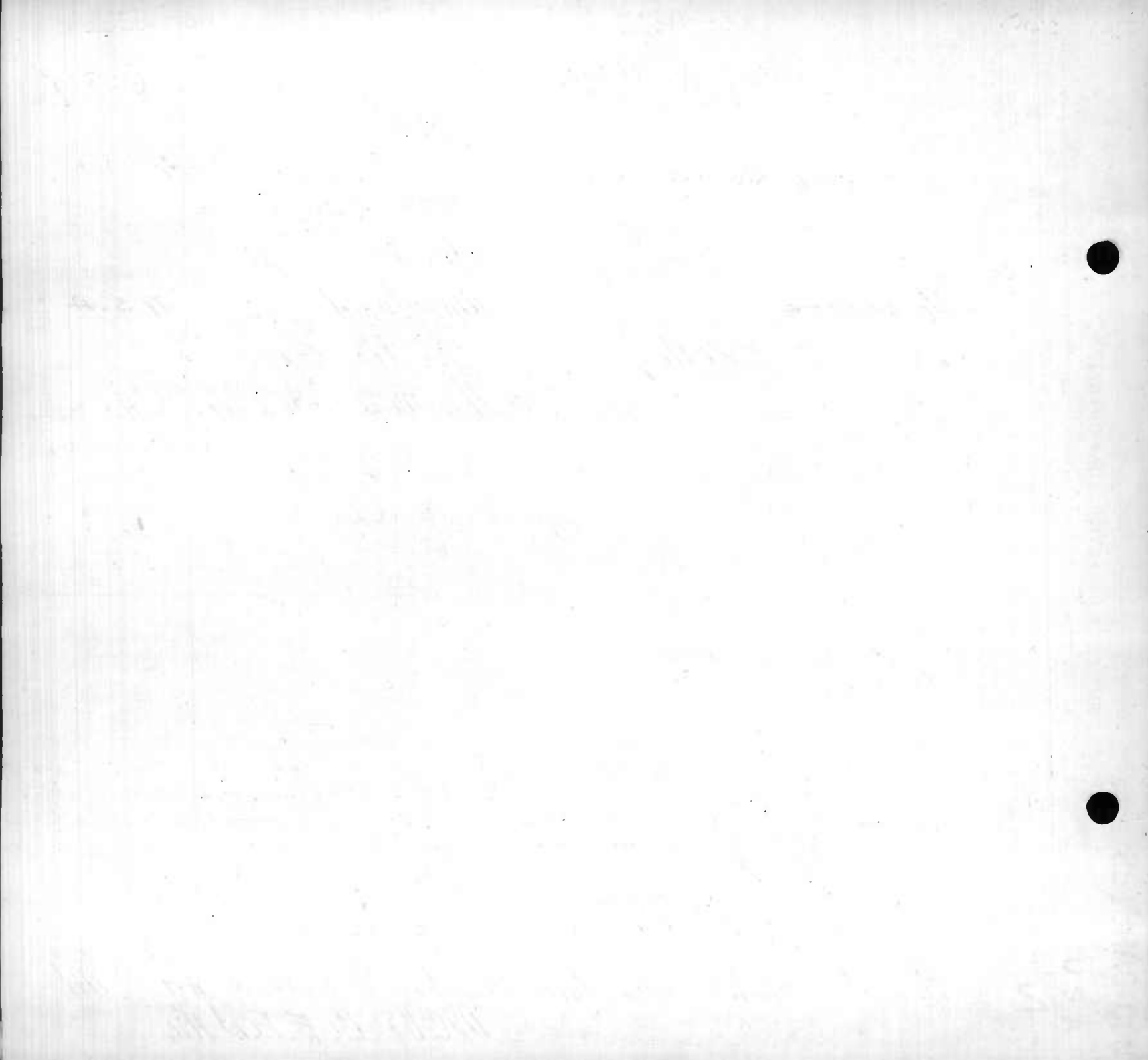
10-2-10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9230	
BIRTH NO. 260				68- 9230	
1. NAME OF DECEASED (Type or Print) ANNAR Fisher (ANNA R. FISHER)				2. DATE AND HOUR OF DEATH 9-6-68 4:16 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital 4940 EASTERN AVE., BALTO., MD. 21224				C. CITY OR TOWN Harbor View D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 503 S. 48th ST. 21224					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-92	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME THOMAS GACKOWSKI				14. MOTHER'S MAIDEN NAME ANTOINETTE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-01-4159-B		17. INFORMANT BCH: 4940 EASTERN AVE. RECORDS: BALTIMORE, MD. 21224	
18. 410.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial infarction Coronary atherosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 hrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Longstanding hypertension					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 3 19 68 to Sept 6 19 68 , that (I) (and) last saw the deceased alive on Sept 6 19 68 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
23A. SIGNATURE Ronald G Michels MD				23B. DATE SIGNED 9-6-68	
23C. PHYSICIAN'S NAME (Type) RONALD G. MICHELS M.D.				23D. ADDRESS BCH 4940 EASTERN AVE. BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-10-68		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Ba. Co., Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 11 1968		24F. NAME OF REGISTRAR Robert E. Fisher, MD	
24G. FUNERAL DIRECTOR Charles S. Geiler		24H. ADDRESS 6224 Eastern Ave. Balto., 21224, Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

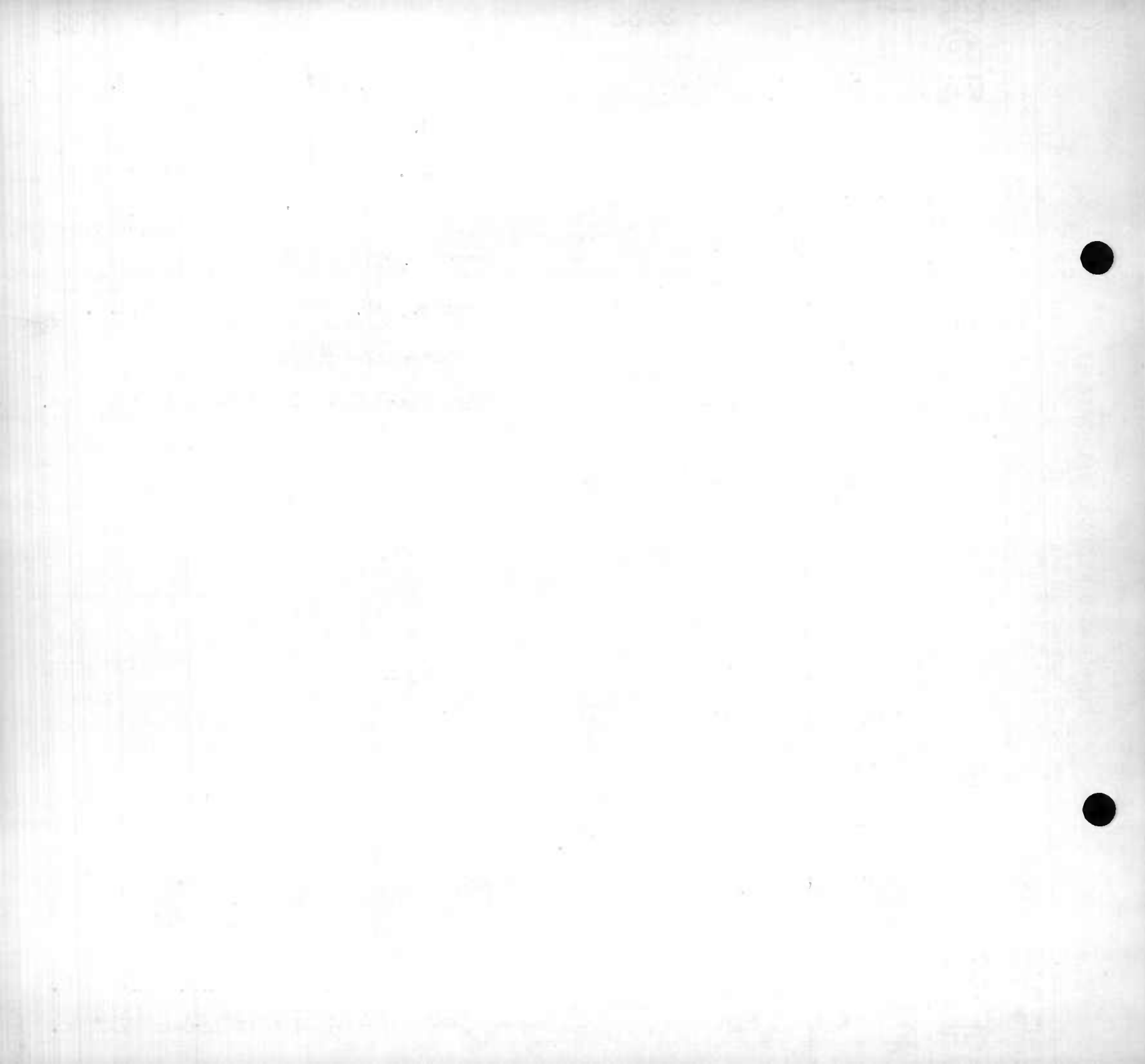
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9231	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Mary A. Meyd</p> </div> <div> <p>2. DATE AND HOUR OF DEATH</p> <p>9-9-68 6:30 P. M.</p> </div> </div>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>1438 Riverside Ave.</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Md. B. COUNTY</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 1438 Riverside Ave.</p>		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/19/87	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John M. Skelley		14. MOTHER'S MAIDEN NAME Nellie GRIFFIN		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-10-6140		17. INFORMANT Mrs. Meyd ADDRESS 1438 Riverside Ave.	
<p>18. 410.9 I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF: minutes</p> <p>(B) General arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: years</p> <p>(C) _____</p>					
<p>19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
<p>22. I certify that (I) (this hospital) attended the deceased from 8-17-1964 to 9-9-1968, that (I) (we) last saw the deceased alive on 8-14-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>					
23A. SIGNATURE C. C. Chiu DEGREE M.D.				23B. DATE SIGNED 9-9-68	
23C. PHYSICIAN'S NAME (Type) C. C. CHIU, M.D.				23D. ADDRESS 1 E. Randall St. 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/13/68		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) Glen Burnie AA Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 11 1968			
25A. NAME OF REGISTRAR Robert E. Jackson		25B. FUNERAL DIRECTOR McCully ADDRESS 130 E. Fort Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9232	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Keating, Naomi</i>		2. DATE AND HOUR OF DEATH <i>Sept. 7, 1968 11:45 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>42 Sinai Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY _____		
			C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>5613 Wayne Ave.</i>		
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1, 1902</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Harry K Colehouse</i>		
14. MOTHER'S MAIDEN NAME <i>Margaret Kahler</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		
16. SOCIAL SECURITY NO. -----			17. INFORMANT <i>Miss Naomi Jean Keating-5613 Wayne Ave.</i>		
18. <i>4369 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CUA</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>331X II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-7-1968</i> to <i>9-7-1968</i> , that (I) (was) last saw the deceased alive on <i>9-7-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Hosenstein</i>				23B. DATE SIGNED <i>9-7-68</i>	
23C. PHYSICIAN'S NAME (Type) DEGREE _____				23D. ADDRESS <i>42 Sinai Hospital</i> DEGREE _____	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/11/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i>	
24D. LOCATION <i>Woodlawn- Balto. Co.- Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>John T. Stansbury</i>	
ADDRESS <i>6411 Windsor Mill Rd.</i>					



1
B-522

68- 9233 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9233

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GARY J. BONCEWICH

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 4, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

(DOA)

South Baltimore General Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 4, 1968

9:27 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

BALTIMORE

6. SEX

Male

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

9. DATE OF BIRTH

June 14, 1949

10. AGE (In years
lost birthday)

19

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

8043 N. Boundary Road

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Boncewich

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Florence Gallagher

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

218-48-2734

18. INFORMANT (Father)

ADDRESS

Dundalk, Md.

Mr. John Boncewich, 8043 N. Boundary Rd.

19. E8150 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Multiple severe injuries of head

(A) IMMEDIATE CAUSE

and thorax

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

highway

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?Harbor tunnel thruway
1850' south of Potee Street22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

9-4-68 8:48 P. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Driver in auto-fixed object collision

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/8/68

24C. NAME OF CEMETERY or CREMATORY

Holy Trinity Russian
Orthodox Cemetery

24D. LOCATION

(City, town, or county)

(State)

Elkridge, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1968

25B. NAME OF REGISTRAR

Robert E. Springate

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

100-100

A

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

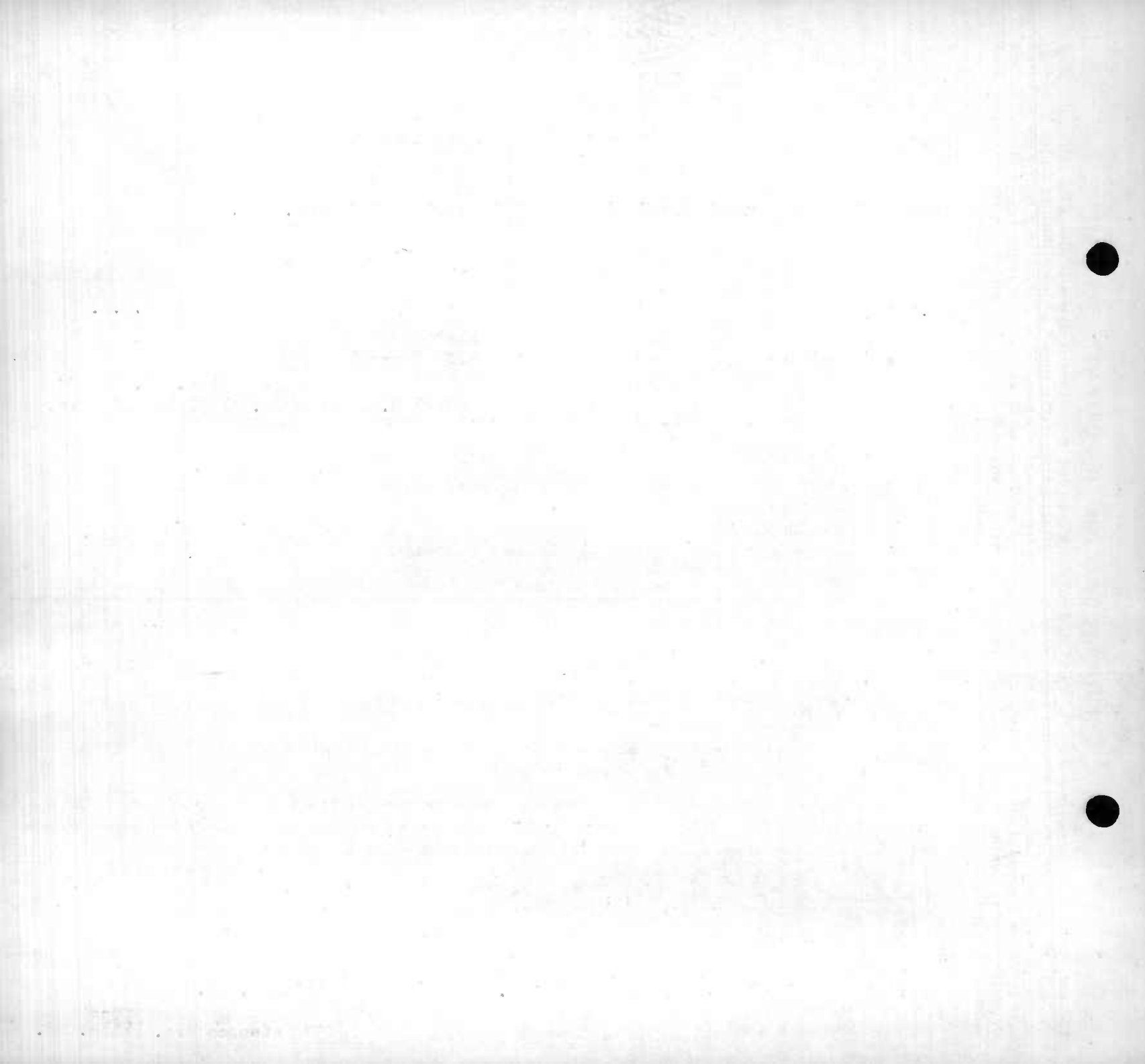
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT
68- 9234 CERTIFICATE OF DEATH**

REG. NO. **68- 9234**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Gladys Lehmann		2. DATE AND HOUR OF DEATH 9-10-68 2:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: 43 South Baltimore General Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: Baltimore C. CITY OR TOWN: Baltimore D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER: 1801 Letitia Ave.	
5. SEX: Female	6. RACE: White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: 1/4/02	9. AGE (In years last birthday): 66	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY?: U.S.A.		13. FATHER'S NAME: Frank Campaigine		14. MOTHER'S MAIDEN NAME: Sarah Mary Connell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No		16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT: Carl H. Lehmann Jr. ADDRESS: Balto. Md. 21230 1801 Letitia Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 412.21 Spont. Subarachnoid Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 14 days (B) Multilobed Aneurysm @ Int. Carotid Artery years (C) Hypertensive Arteriosclerotic Cardiovascular Disease years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 473 X II None					
19A. DATE OF OPERATION: None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: None		20A. AUTOPSY? (Yes or No): No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner): <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None	
21D. TIME OF INJURY (APPROX.): (Month) (Day) (Year) (Hour): None		21E. INJURY OCCURRED: While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?: None	
22. I certify that (I) (this hospital) attended the deceased from August 27 1968 to Sept. 10 1968 , that (I) (we) lost saw the deceased alive on Sept 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE: Franklyn W. Colligan M.D. DEGREE				23B. DATE SIGNED: 9-10-68	
23C. PHYSICIAN'S NAME (Type): Franklyn W. Colligan M.D. DEGREE				23D. ADDRESS: 4315 McDowell Lane (27)	
24A. BURIAL CREMATION, REMOVAL (Specify): Burial		24B. DATE: 9/13/68		24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cem.	
24D. LOCATION: Baltimore, Md.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT.: SEP 11 1968		25B. NAME OF REGISTRAR: Robert E. Fisher		25C. FUNERAL DIRECTOR: Miss Cully ADDRESS: 2737 Patapsco Ave. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9235
BIRTH NO.		68- 9235		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SARAH GILES BROWN			2. DATE AND HOUR OF DEATH 9-10-68 1:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21216		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland 46			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2824 Clifton Ave		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-83	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Rosie McIver 2507 Loyola I Way	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. If means the disease, injury or complication which caused death.) Cardiorespiratory failure		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) A.S.C.U.O. DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-13-1968 to 9-10-1968 , that (I) (we) last saw the deceased alive on 9-10-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MBang				23B. DATE SIGNED 9-10-68	
23C. PHYSICIAN'S NAME (Type) DR. BALC				23D. ADDRESS LUTHERAN HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-68		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR, R. Bailey, Mgr. ADDRESS 1348 N. Calhoun St.	

9-18-83 84
Mh

Police Report 201-1-1

9-18-83 84
Mh
John F. H. 1982 N. 101-1-1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9236

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Barnacle Abell HALEY

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☒ September 9, 1968 4:10 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour
September 9, 1968 5:25 P.M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

12-11-16

10. AGE (In years last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1236 Darley Avenue

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John McClain

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Construction

14B. KIND OF BUSINESS OR INDUSTRY

Patton Cons. Co.

15. MOTHER'S MAIDEN NAME

Betty Haley

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

17. SOCIAL SECURITY NO.

18. INFORMANT

LulaBell Haley

ADDRESS

same

19. E916 IX

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Suffocation

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

5100 Falls Road - Village of Cross Keys

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

9/9/68 4:05 P. m.

22E. INJURY OCCURRED

WHILE AT WORK ☒NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

Subj. buried under dirt while operating back hoe.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/10/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-13-68

24C. NAME of CEMETERY or CREMATORY

Balto. Nat'l. Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

V.R. Bailey Kelson F. H. 1348 N. Calhoun St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9237
68-9237		CERTIFICATE OF DEATH		X
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GALATOLO, AMERIGO		2. DATE AND HOUR OF DEATH SEPT-8-1968 11:45 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY BaltCo 53-00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1223 63rd ST.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-7-99	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Am. Standard	11. BIRTHPLACE (State or foreign country) ITALY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME STEVE GALATOLO		14. MOTHER'S MAIDEN NAME MARY BELLERI-		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-3932	17. INFORMANT Steven Galatolo	
18. 441.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypovolemic shock (B) Ruptured aortic aneurysm (C) Atherosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 451X II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from 9-6-1968 to 9-8-1968, that (we) last saw the deceased alive on 9-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				
23A. SIGNATURE Joseph Notarangelo M.D.		23B. DATE SIGNED 9-9-1968		23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer
24D. LOCATION Baltimore Maryland		24E. ADDRESS Joseph N. Zannino 263 S. Conkling St.		
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Tashy, M.D.		25C. FUNERAL DIRECTOR Joseph N. Zannino 263 S. Conkling St.

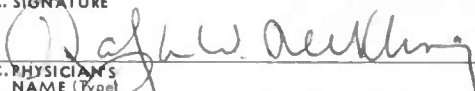
Hypocyanus ruber
hypocyanus ruber
hypocyanus ruber

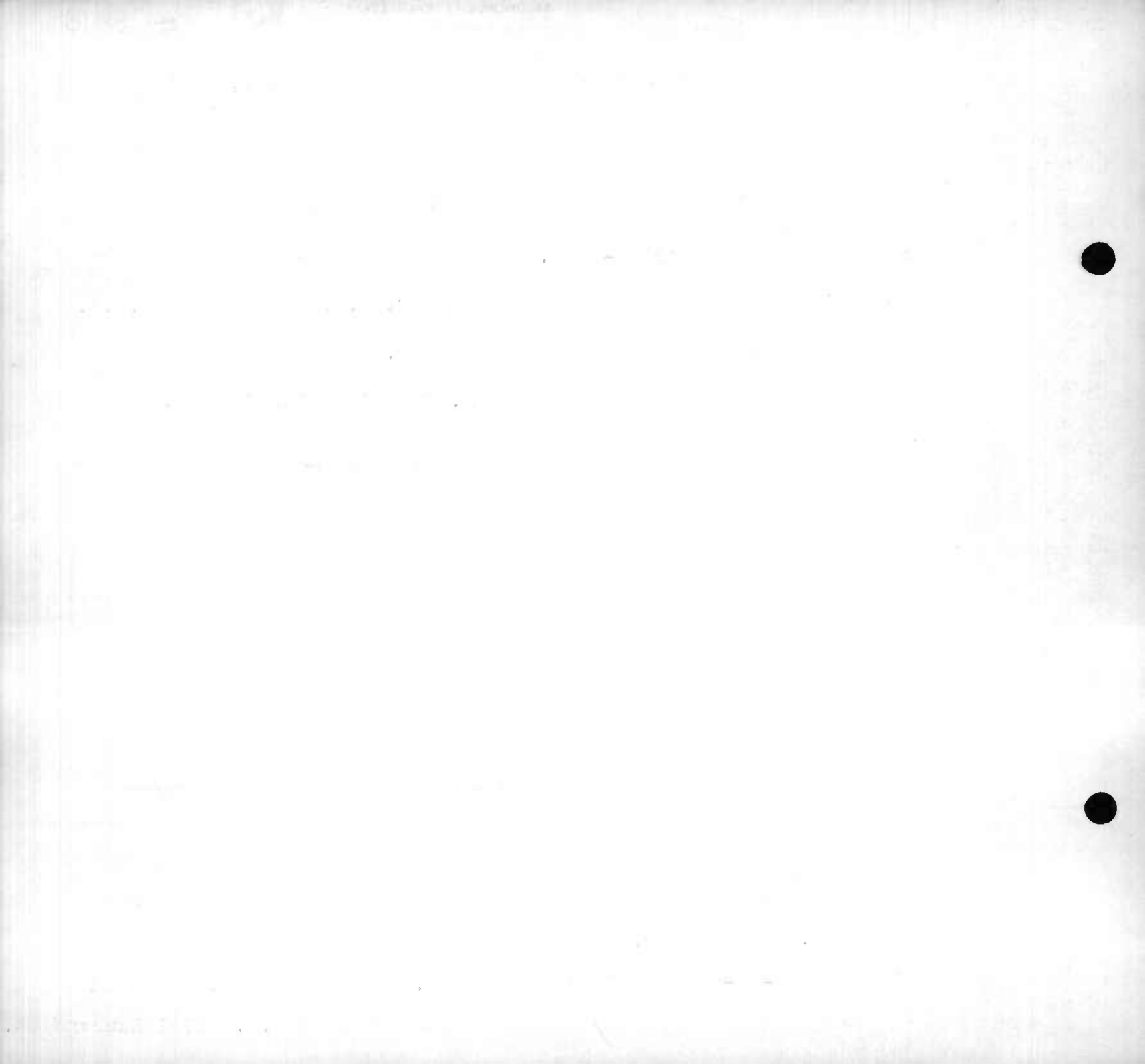
0/0

7-9
JAN 192-18 1030M

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 9238				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 9238	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				CLEVELAND STALEY		September 7, 1968	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 4100 Glenhunt Road				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				4100 Glenhunt Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Male	Negro	Married- Sep.	5-1-14	54			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Construction				Denmark, S.C.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Fess Staley				Unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
					Mr. Jeremiah Fickling 4100 Glenhunt		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Hypertensive Cardio-vascular Disease		Two years	
				(B) DUE TO			
				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/9/57 to 4/29/68 that (I) (we) last saw the deceased alive on 4/29/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
 M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						9/9/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Ralph W. Reckling, M.D.				1401 A Edmondson Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-12-68		Baltimore Nat'l Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 11 1968		Robert E. Fickling		MORTON & DYETT F.H.		1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9239 CERTIFICATE OF DEATH

REG. NO. 68- 9239

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GRAY, WILLIE MAE		2. DATE AND HOUR OF DEATH SEPT. 9, 1968 9:11 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY OF MARYLAND HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSES AID		10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (State or foreign country) Greenville, S.C.	
13. FATHER'S NAME WILLIAM WILSON				14. MOTHER'S MAIDEN NAME MARIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORD	
18. 207.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) HYPERPYREXIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PSEUDOMONAS PNEUM. & STAPH BACTER. CMIA PLASMA CELL LEUKEMIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS 1 WK 1 YR	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 204.4 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT 3 19 68 to SEPT 9 19 68 , that (I) was last saw the deceased alive on SEPT 9 19 68 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Deegan, M.D.				23B. DATE SIGNED 9/9/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS UNIVERSITY OF MARYLAND HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-68		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968			
25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.			

68- 9240 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9240

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MATTIE SQUIRREL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 4, 1968 9:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 4, 1968 9:10 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-6-1883		10. AGE (In years last birthday) 84	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. 215-16-7965	
18. INFORMANT Mrs. Nora Brightful		ADDRESS 530 Johansen St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Diabetes Mellitus		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED September 4, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	

Paul M. Miller

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9241

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Hilde, George</u>		2. DATE AND HOUR OF DEATH <u>9/6/68</u> <u>4:45 PM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>18-02</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>27 N. Carey St.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Lincoln Nursing Home</u> <u>27 N. Carey St.</u> <u>Baltimore, Maryland</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <u>male</u>	6. RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/19/97</u>	9. AGE (In years lost birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-36-5816</u>		17. INFORMANT <u>unknown</u>	
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive Cardio Vascular Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>443X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Cardio Vascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> 19 <u>65</u> to <u>9/6</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/6</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Hollis Sennarine, Sr.</u> DEGREE		23B. DATE SIGNED <u>9/6/68</u>		23C. PHYSICIAN'S NAME (Type) <u>HOLLIS SENNARINE</u> DEGREE	
23D. ADDRESS <u>1801 GREENBERRY RD.</u>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/14/68</u>	
24C. NAME of CEMETERY or CREMATORY <u>St. Catherine's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1968</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Wm. P. Howell</u>		25D. ADDRESS <u>1714 W. North Ave</u>	

1
The above is a
copy of the original
manuscript of the
first volume of the
History of the
County of
Gloucester
from the year
1086 to 1540
as far as the
original manuscript
has been preserved
and is now in the
possession of the
County of Gloucester
Museum.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9242

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES L. HARRIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 6, 1968		Hour 1:25 P.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year September 6, 1968		Hour 1:25 P.
6. SEX Male		7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH July 23, 1941		10. AGE (In years lost birthday) 27	11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Charles C. Harris		14. MOTHER'S MAIDEN NAME Bernice Rose Brady
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 215 36 1841		18. INFORMANT Mrs Flora Helen Harris
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E950.1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E970.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1626 E. 30th St.
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9 ? 68 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject ingested overdose
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 7, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/10/68	24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc. Baltimore, Maryland 21213

68- 9243

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9243

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rosa Laura Garbuglia ROSA GARBUGLIA		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 8, 1968		Hour 5:15 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year September 8, 1968		Hour 5:15 P.	
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Mar. 1, 1897		10. AGE (In years last birthday) 71		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Antonio Lambertucci		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-05	
15. MOTHER'S MAIDEN NAME Maria Romitelli		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 213-09-1759 D	
18. INFORMANT Antoinette DeAngelo		19. CAUSE OF DEATH Laennec's cirrhosis of liver with fatty metamorphosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 520 S. Rappola Street	
22D. TIME OF INJURY (APPROX.) 9-8-68 about 3:00 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell down stairs at home	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) DATE SIGNED September 9, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Fickelmaier	
25C. FUNERAL DIRECTOR Joseph N. Zannino		25D. ADDRESS 263 S. Conkling St.			

()

...

...

...

...

...

...

...

...

...

...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9244

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 9244

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROLAND L. RICER

2. DATE AND HOUR OF DEATH

SEPT. 9, 1968 4:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MD 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

WEST VIRGINIA

C. CITY OR TOWN

FAIRMONT

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

501 MORGANTOWN AVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1-29-27

9. AGE (In years last birthday)

41

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Proprietor

10B. KIND OF BUSINESS OR INDUSTRY

Florist

11. BIRTHPLACE (State or foreign country)

Gypsy, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

EDGAR J. RICER

14. MOTHER'S MAIDEN NAME

BESSIE
BOSS MCCARTNEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL SECURITY NO.

235-34-2962

17. INFORMANT

Carpenter & Ford F. H.

ADDRESS

Fairmont, W. Va.

18. 577.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE CARDIO-RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF:

(B) LACTIC ACIDOSIS - SEPTICEMIA 12 hrs
DUE TO, OR AS A CONSEQUENCE OF:

(C) ACUTE HEMORRHAGIC PANCREATITIS 5-6 wks
DUE TO, OR AS A CONSEQUENCE OF:

587.0 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

8/8/68 & 8/15/68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

ACUTE PANCREATITIS

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 8-7 19 68 to 9-9 19 68, that (1) (we) last saw the deceased alive on 9-9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Vernon T. Tolo, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Sept. 9, 1968

23C. PHYSICIAN'S NAME (Type)

VERNON T. TOLO M.D.

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Rem. Burial

24B. DATE

9/11/68

24C. NAME of CEMETERY or CREMATORY

Grandview

24D. LOCATION

Fairmont,

W. Va.

25A. DATE REC'D BY HEALTH DEPT.

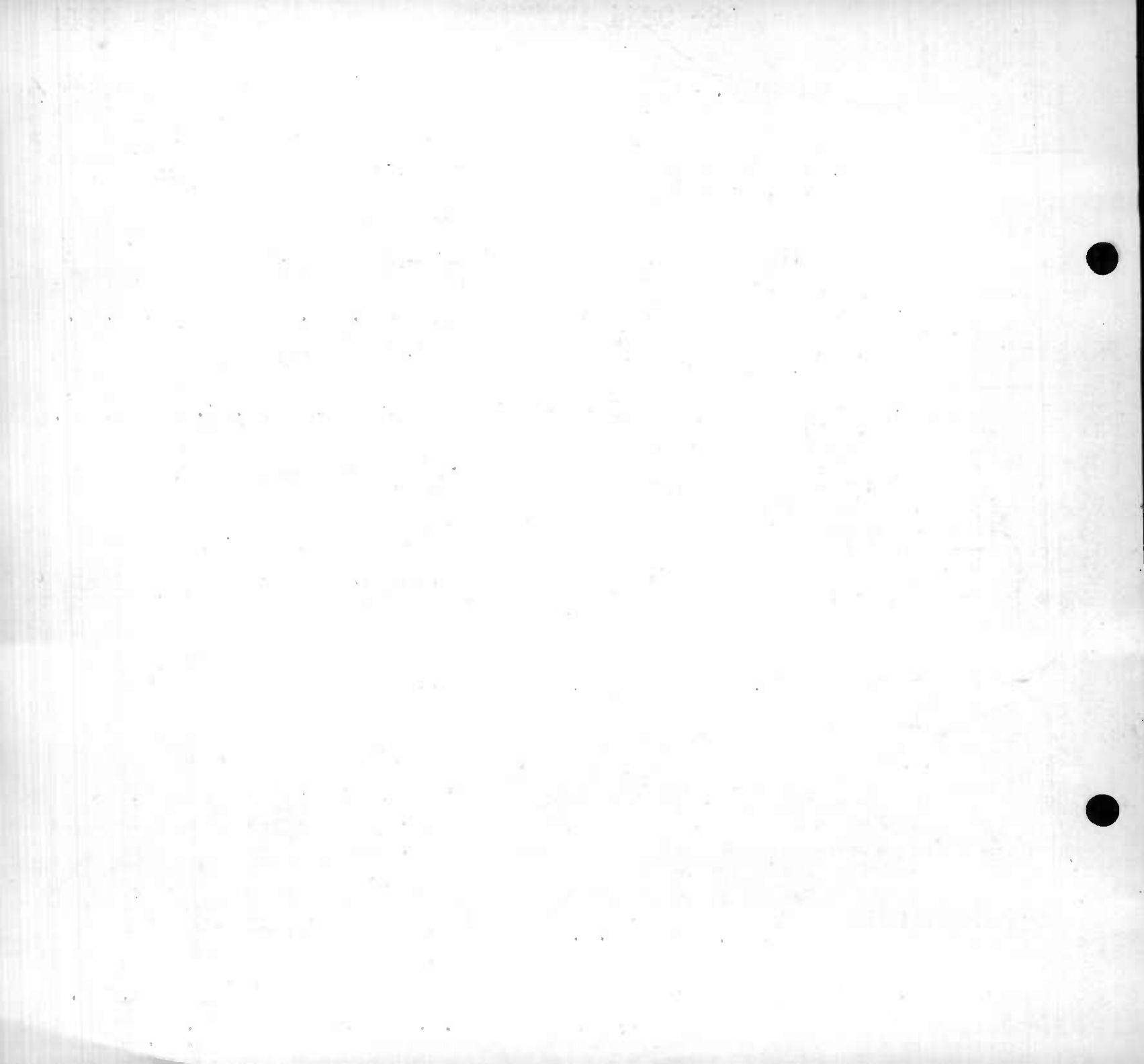
SEP 11 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd
Balto. 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9245 CERTIFICATE OF DEATH

REG. NO. 68- 9245

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Louis Wilmer Lohrfink		Sept. 8, 1968 1 0 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 206 Chancery Road	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1881	9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Credit Mgr.		10B. KIND OF BUSINESS OR INDUSTRY Gen. Elec. Supply Corp.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John Lohrfink				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-09-8724	
				17. INFORMANT Mrs. W. Winchester White	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 486X I		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 493X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 29 1962 to FEBRUARY 3 1966, that (I) (we) last saw the deceased alive on FEBRUARY 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph King M.D.				23B. DATE SIGNED 9-10-68	
23C. PHYSICIAN'S NAME (Type) Dr. Joseph D. B. King				23D. ADDRESS 2 Hamill Rd. (Cross Keys)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/68		24C. NAME of CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Woodlawn, Balto. Co., Md.		24E. CITY, town, or county Balto. Co., Md.		24F. STATE Md.	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

901

Handwritten signature

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9246	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) (Bill) WILLIAM STONEY		2. DATE AND HOUR OF DEATH 9/8/68 2:39 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL 33RD & CALVERT STS.		C. CITY OR TOWN BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 729 BARTLETT AVE 21218	
5. SEX MALE	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-1899	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Mill Co.		11. BIRTHPLACE (State or foreign country) SC	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Ned Stoney		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W. W. I		16. SOCIAL SECURITY NO. 245-09-0160		17. INFORMANT Mrs Bessie Lee Green ADDRESS 729 Bartlett Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 422.1 II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARDIO-RESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EDEMA (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) DIABETES MELLITUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/8 1968 to 9/8 1968 and that (I) (we) lost saw the deceased alive on 9/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald M. Legum MD		23B. DATE SIGNED 9/8/68		23C. PHYSICIAN'S NAME (Type) RONALD M. LEGUM MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 9-10-68		24C. NAME OF CEMETERY or CREMATORY Salem Cemetery	
24D. LOCATION (City, town, or county) (State) Bucksport, S.C.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Randolph J. Collick		25D. ADDRESS 243 E. Oliver St.			

Page 100

THE PATIENT

MALE

THE PATIENT

THE PATIENT

THE PATIENT

THE PATIENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO 68- 9247	
68- 9247				CERTIFICATE OF DEATH	
BIRTH MO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		PLUMMER, Melroy A.		9/5/68 11:10 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
The Johns Hopkins Hospital				Maryland Balto	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Male Negroid WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 6-26-56 12				Baltimore	
Student School				1107 Springfield Ave.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Samuel Plummer				Melray Bullock	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO				NAME	
17. INFORMANT				ADDRESS	
Mrs. Melray Plummer				1107 Springfield Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				5 MIN.	
ANTECEDENT CAUSES				CARDIAC ARREST	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				24 HRS.	
754.2 II				12 YRS.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				~ 8 YRS.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1 9/4/68		CONGESTIVE HEART FAILURE.		NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work			
22. I certify that (I) (this hospital) attended the deceased from 9/23 19 68 to 9/5 19 68, that (I) we lost saw the deceased alive on 9/5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Mark B. Ominger, M.D.					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
23E. DEGREE				23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				9-9-68	
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Arbutus Memorial Park				Arbutus, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 11 1968		R. B. J. Jones		Randolph J. Collick 2431 E. Oliver St.	

OUTLINE AREA

1. STATE THE PROBLEM

2. ANALYZE THE PROBLEM

3. DEVELOP A PLAN

4. EXECUTE THE PLAN

5. EVALUATE THE RESULTS

6. CONCLUDE

7. REFLECT

8. REVISIT

9. REEVALUATE

10. RECONSTRUCT

11. RECONSTRUCT

12. RECONSTRUCT

13. RECONSTRUCT

14. RECONSTRUCT

15. RECONSTRUCT

16. RECONSTRUCT

17. RECONSTRUCT

18. RECONSTRUCT

FUNERAL DIRECTOR: IMPORTANT

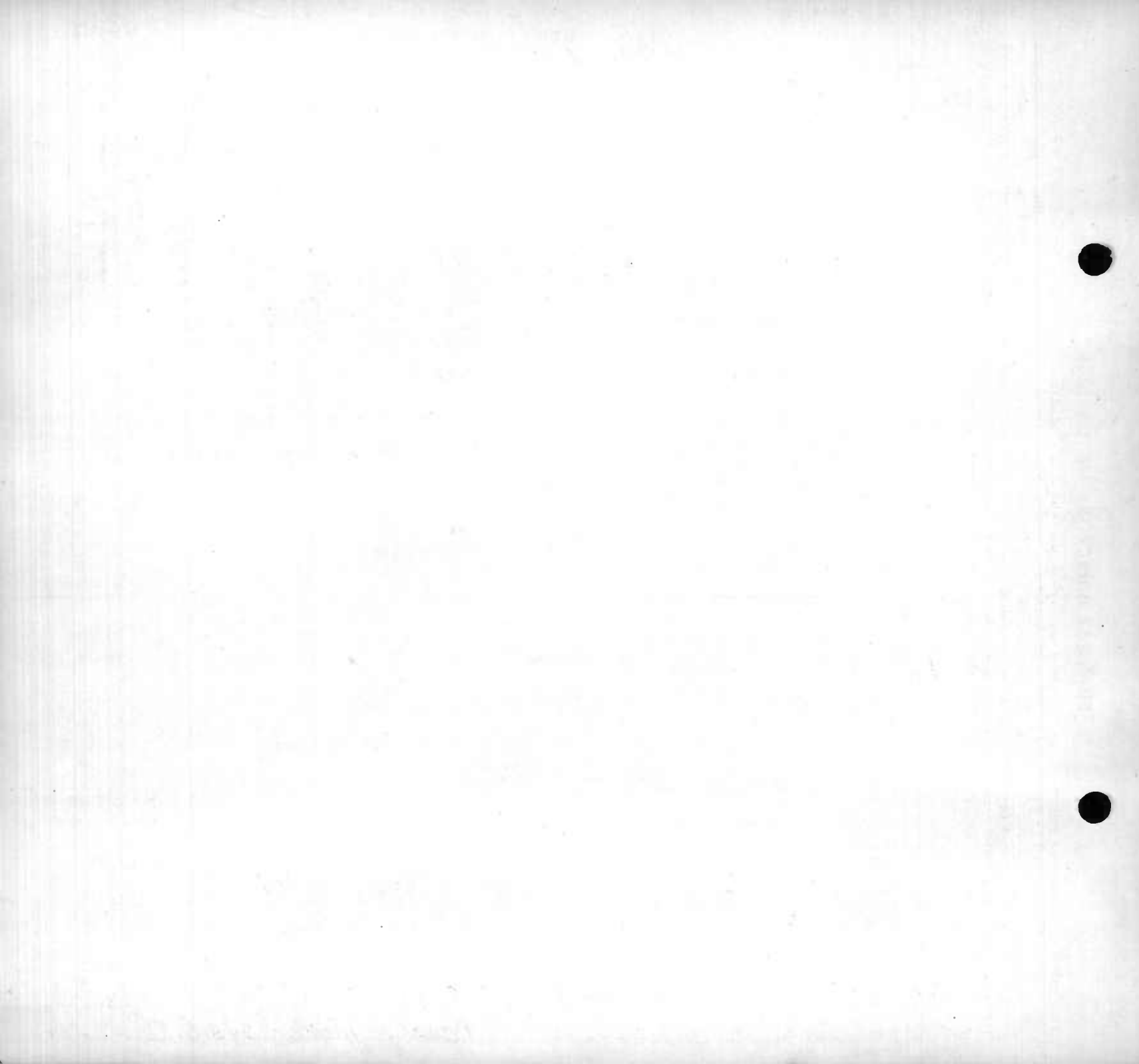
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9248 CERTIFICATE OF DEATH

REG. NO. 68- 9248

BIRTH NO. 68- 9248		1. NAME OF DECEASED (Type or Print) ALEXANDER HIPP		2. DATE AND HOUR OF DEATH 9-3-68 11 30 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSP.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE BALTO. B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2628 E. PRESTON ST.		
5. SEX M	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/02		9. AGE (In years lost birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ICE CUTTER			11. BIRTHPLACE (State or foreign country) S. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO.		17. INFORMANT PH. CHART. ADDRESS
18. 402X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH cardio vascular accident (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Brain Hemorrhage - years (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Heart Disease (C)		
19. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8-28 19 68 to 9-3 19 68 , that (I) (we) last saw the deceased alive on 9-3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 9-3-68		23C. PHYSICIAN'S NAME (Type) Dr. [Signature]
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-8-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cmtv.
24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL Co., Md.			25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		
25B. NAME OF REGISTRAR R. E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.		



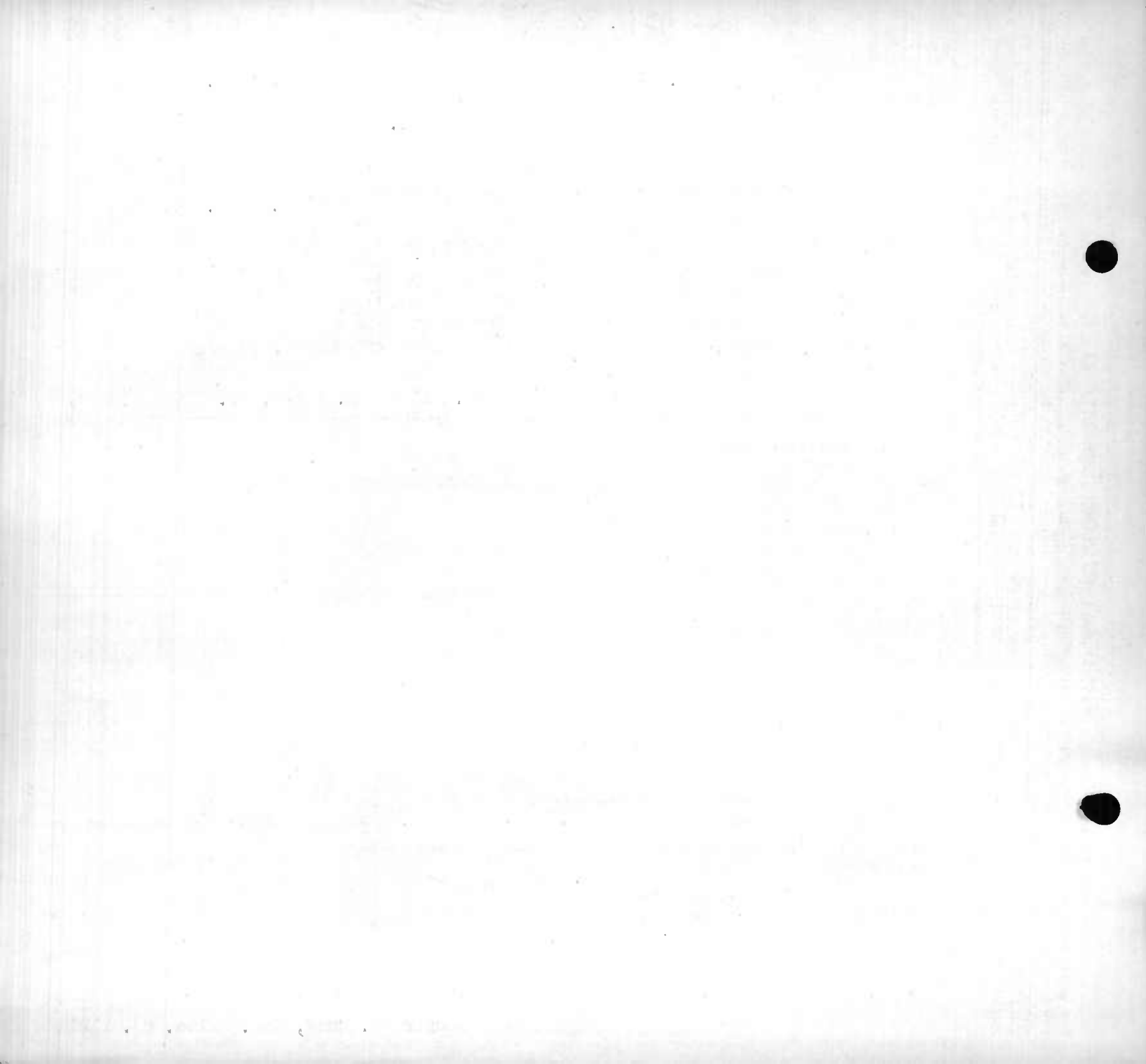
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9249 CERTIFICATE OF DEATH

REG. NO. 68- 9249

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JULIA A. LANCE		September 9, 1968. 7:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Could Convalesarium				A. STATE Md. B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1704 E. 29th. Street	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/24/1897	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George P. Wagner		14. MOTHER'S MAIDEN NAME Anna M. Ruppel		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216484465		17. INFORMANT Mr. William R. Lange, Sr.	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 737.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH Cerebral Arteriosclerosis 3 year				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 334 X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to Sept 1968, that (I) (we) last saw the deceased alive on Sept. 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman MD. DEGREE				23B. DATE SIGNED 9/9/68	
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman MD. DEGREE				23D. ADDRESS 3202 Hartford Rd Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9250

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Helen Zoumadakis</u>		2. DATE AND HOUR OF DEATH <u>9.8.68</u> <u>9.30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secours Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>ALB</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>		E. STREET AND NUMBER <u>1647 Argonne Dr.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. SEX <u>Female</u> 6. RACE <u>Greek</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
13. FATHER'S NAME <u>John Tjamarias</u>		14. MOTHER'S MAIDEN NAME <u>Daskaloyiane, Anna</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Nick Zumas-1647 Argonne Dr.</u>	
18. <u>238.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Brain Tumor</u> (B) <u>Complications of brain Tumor</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>months</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>237X II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9.1</u> 19 <u>68</u> to <u>9.8</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9.8</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Keyhani</u>		23B. DATE SIGNED <u>9.8.68</u>		23C. PHYSICIAN'S NAME (Type) <u>M. Keyhani M.D.</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/12/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greek Orthodox Cem.,</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24F. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. #14</u>	

1870

On 2nd Dec 1870
A Green
the Transpacific

On 2nd Dec 1870
A Green
the Transpacific

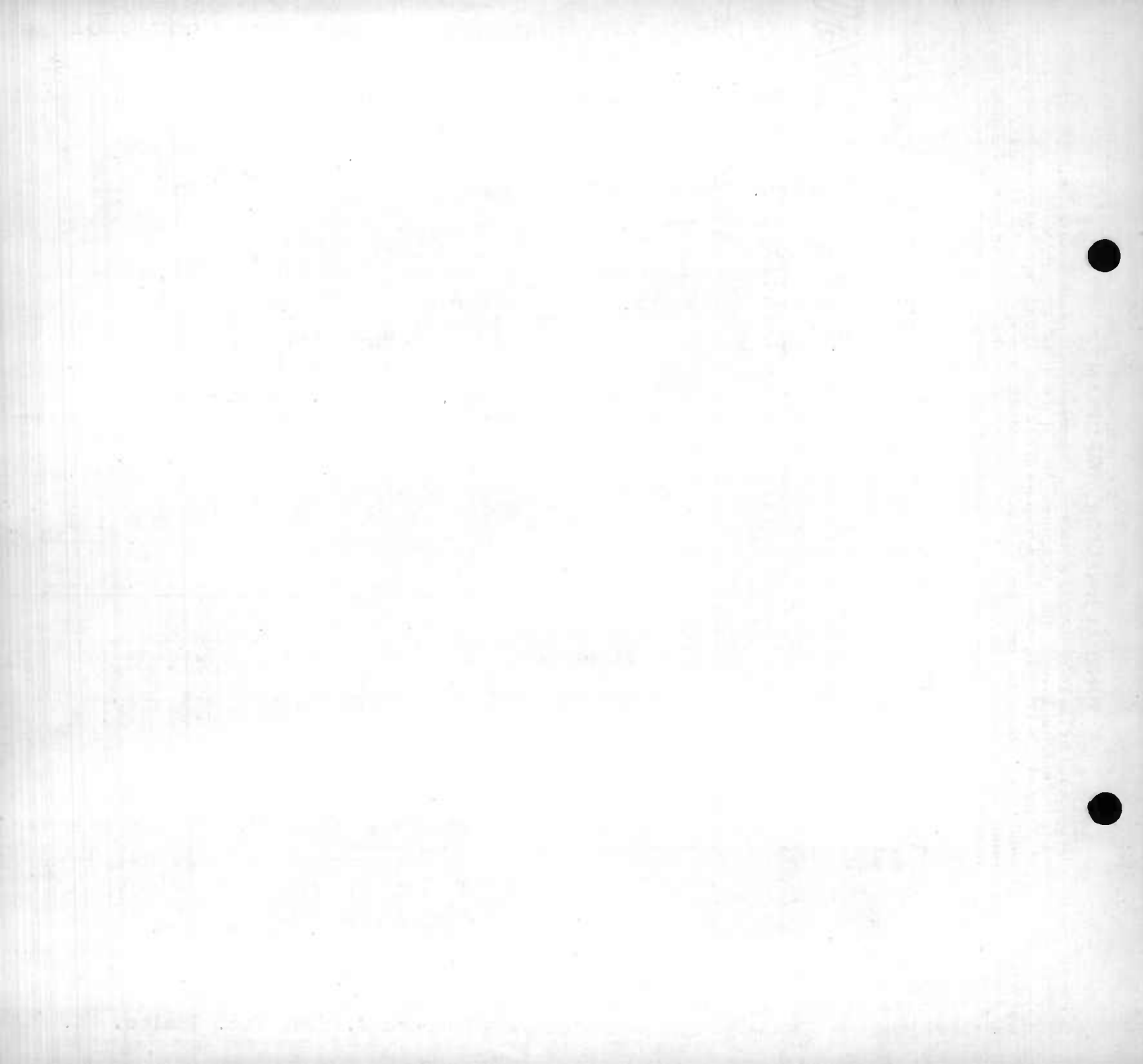
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9251 CERTIFICATE OF DEATH

REG. NO. 68- 9251

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDWARD M. NAPFEL		2. DATE AND HOUR OF DEATH 9 SEPT 68 3 05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Balto. General Hosp				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4108 Eastmont Ave.	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1898	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker		10B. KIND OF BUSINESS OR INDUSTRY Penna. RR		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward M. Napfel			
14. MOTHER'S MAIDEN NAME Christina Koestner				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 717076963		17. INFORMANT ADDRESS Mrs. Bertha E. Napfel- Same			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>central nervous system accident</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>diabetes m.</u> (C) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260X II <u>wound from infection</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 30 AUG 19 68 to 9 SEPT 19 68 , that (I) (we) last saw the deceased alive on 9 SEPT 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H.E. Mendelrohn M.D.				23B. DATE SIGNED 9 SEPT 68	
23C. PHYSICIAN'S NAME (Type) H.E. Mendelrohn		23D. ADDRESS South Balto. General Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/68		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. #14			



FUNERAL DIRECTOR: IMPORTANT

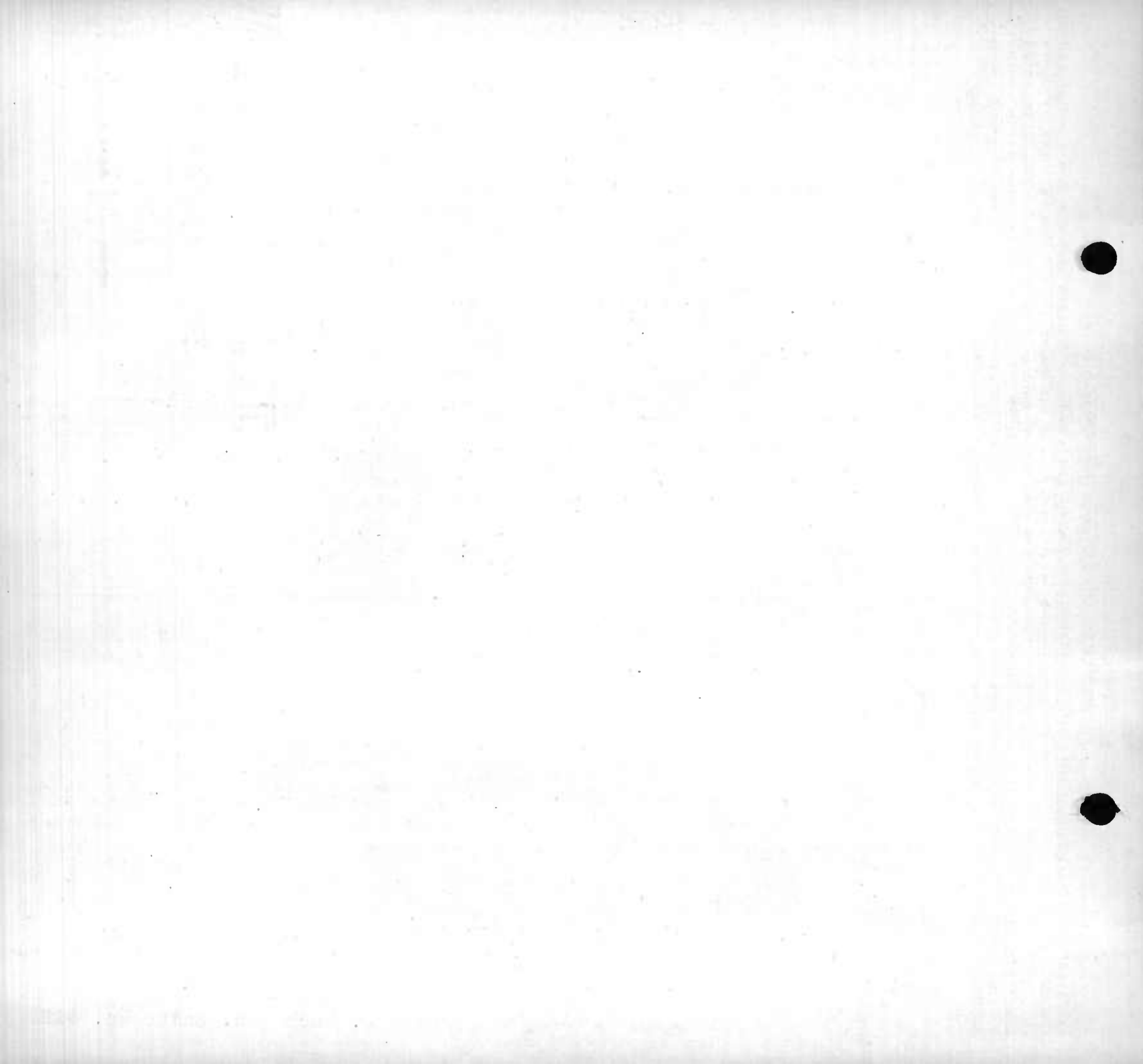
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9252

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. 68- 9252

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HOWARD G. BIGGS		September 9, 1968 10:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
3012 Evergreen Ave.				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3012 Evergreen Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/25/1905	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Office Mgr.		Construction		Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Charles E. Biggs				Sara C. (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		243140225		Mrs. Rachel Smith-3012 Evergreen Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Sudden Myocardial Infarction			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Due to arteriosclerosis			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		German Thrombosis			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 15, 1968 to Sept 9, 1968, that (I) (we) last saw the deceased alive on May 15, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Donald Mintzer				9/9/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				3009 Evergreen Ave. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/11/68		Moreland Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 11 1968		Robert E. Jackson		Leonard J. Ruck Inc. Balto Md. #184	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9253

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) REATA, Beata W. CROOK		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> bet. 9/9/68 and 9/10/68 Month Day Year Hour 9/10/68 10:55 P. 8:15 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 10, 1968 9:25 A.M.	
6. SEX female		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE white		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH 7-29-05		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 211-46-7637	
18. INFORMANT David E. Crook, 6 Upland Rd.		ADDRESS	
19. E 950.0 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Barbiturate Overdose (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> home		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Roland Park Apts.		22F. HOW DID INJURY OCCUR? sub. ingested an overdose of barbiturate	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY bet. 9/9/68 - 10:55 P. & 9/10/68 - 8:15 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/10/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-68	
24C. NAME OF CEMETERY or CREMATORY Lorraine Pk		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Fashola	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.		ADDRESS	

201-1-107

WILLIAM F. POTTS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9254

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JAMES

A.

CUNNINGHAM

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 9, 1968

9:10 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 9, 1968

9:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

5-10-39

10. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

E. STREET AND NUMBER

4840 Greencrest Road

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Guy Cunningham

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Crane Operator

14B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel

15. MOTHER'S MAIDEN NAME

Ada Davis

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.
220-36-1873

18. INFORMANT

ADDRESS

Alice V. Cunningham, 4840 Greencrest Rd.

19. E812.10
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Multiple Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.E816.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?Rte. 151 - North Point Blvd. -
1500 ft. N. of Rosebank22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

9/9/68

8:55 P.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Operator of auto -
which struck a parked trailer

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/10/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-13-68

24C. NAME of CEMETERY or CREMATORY

Holly Hills

24D. LOCATION (City, town, or county)

Balto; Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc., 5305 Harford Rd.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

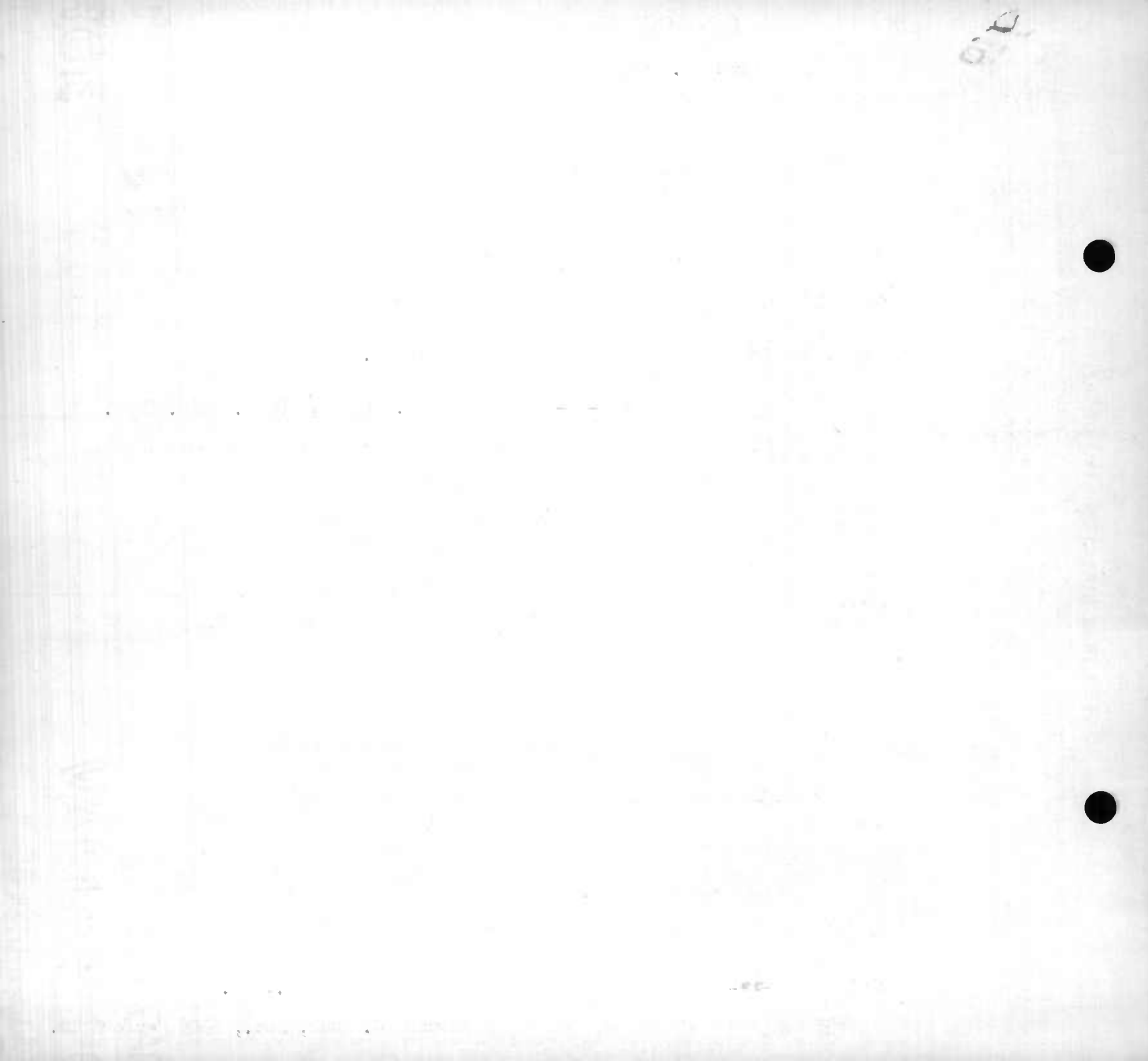
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9255 CERTIFICATE OF DEATH

REG. NO. **68- 9255**

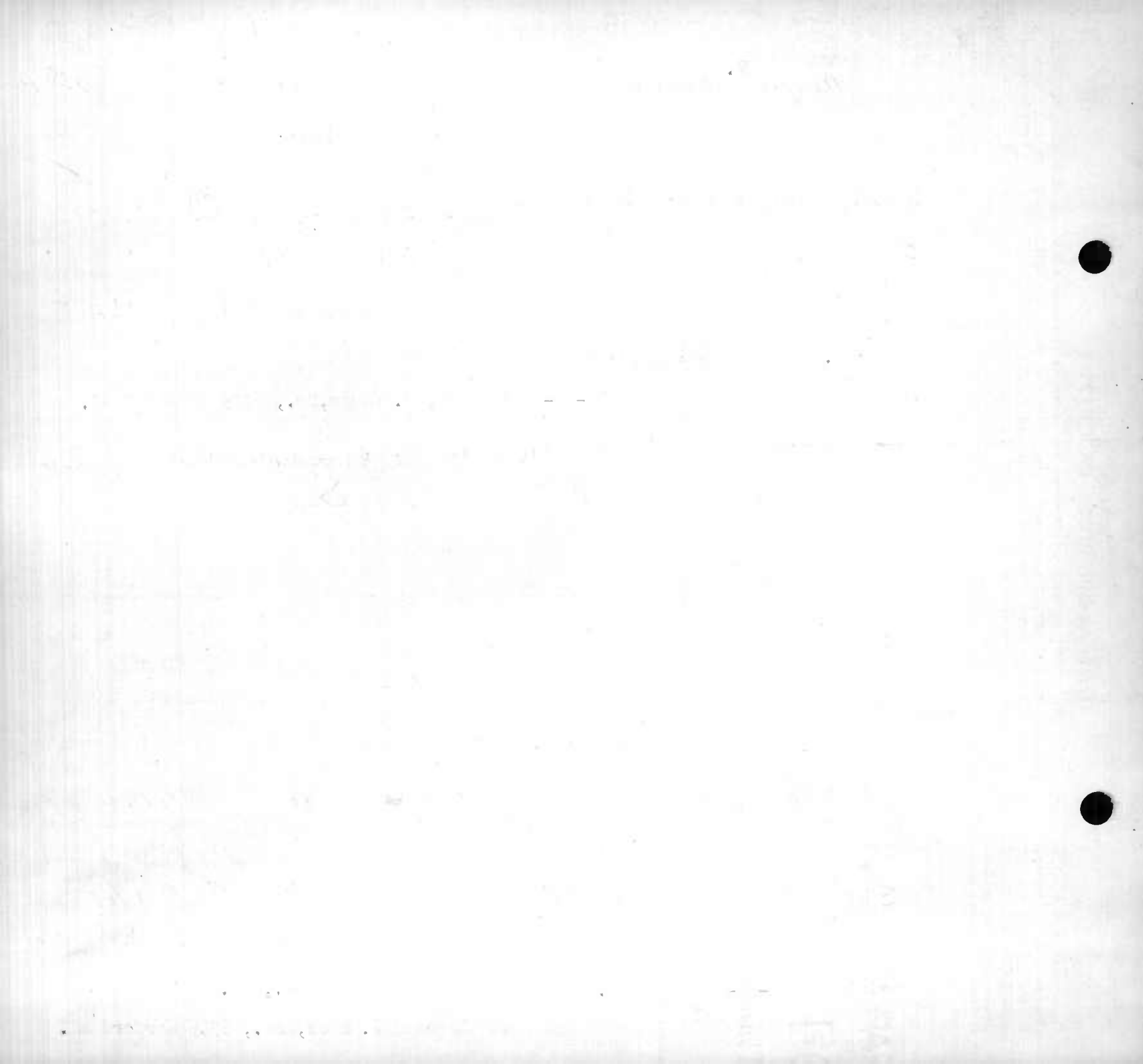
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GRACE M. WATSON (Grace M. Watson)		2. DATE AND HOUR OF DEATH SEPT. 10, 1968 6:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND B. COUNTY	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? 27-38 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1307 RAMBLEWOOD ROAD			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUN. 17, 1885	9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Joseph O. Bunting				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 210-05-9883D	
				17. INFORMANT Henry H. Waters, 608 W. Univ. Pkwy.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.941 15 3.3		CAUSE OF DEATH CARDIO-RESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE ANT. M.I.		2 DAYS	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CA OF SIGMOID COLON				4 YRS.	
19A. DATE OF OPERATION 420.1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 9 1968 to Aug. 10 1968 , that (I) was lost saw the deceased alive on Aug. 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE Henry H. Waters				23B. DATE SIGNED 9-10-68	
23C. PHYSICIAN'S NAME (Type) HONG TI CHUA MD				23D. ADDRESS Union Mem. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-68		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
				24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9256
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Marie V. Bauer		2. DATE AND HOUR OF DEATH 9/9/68 7:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY Balto		
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Baltimore			C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 6729 Longhill Rd 21207		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/31	9. AGE (In years lost birthday) 37	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME George T. Glanville			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-26-8081		17. INFORMANT Louis J. Bauer, Sr., 6729 Longhill Rd.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 436.0 I Hypertensive Encephalopathy (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Encephalopathy (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 334 X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/8/68 19 68 to 9/9 19 68 , that (I) (we) last saw the deceased alive on 9/9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanford H. Mahoney MD				23B. DATE SIGNED 9/9/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS Sinai Hospital Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-68		24C. NAME OF CEMETERY or CREMATORY Balto. National	
24D. LOCATION Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd			
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9257

BIRTH NO.		1. NAME OF DECEASED (Type or Print) XXXXX (Benjamin F. Henry) <i>Benjamin F. Henry</i>		2. DATE AND HOUR OF DEATH <i>9/9/68</i> <i>7:45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <i>27-38</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i> <i>48</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>5820 Edgepark Rd.</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>09/05/99</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>XXXXX Shipping Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Elec. Tool & Mach.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>F. Benjamin Henry</i>		14. MOTHER'S MAIDEN NAME <i>Ella Collison</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>215 01 6318</i>		17. INFORMANT <i>XXXXX-Mrs. Florence A. Henry- Same</i>	
18. <i>1579 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>[REDACTED]</i> (B) <i>Carcinoma of stomach</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several months</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>151X II</i>		19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/26</i> <i>1968</i> to <i>9/9</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>September 9, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Michael Yen</i>		23B. DATE SIGNED <i>9/9/68</i>		23C. PHYSICIAN'S NAME (Type) <i>MICHAEL YEN MD</i>	
23D. ADDRESS <i>Md. General Hosp., Balto. Md.</i>		23E. ATTENDING PHYSICIAN Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/12/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem,</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Jenkins</i>	
24G. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. #14</i>		24H. ADDRESS			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9258

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) EZRA MILLS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 8, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 8, 1968 12:55 P.M.	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2-15-1955	10. AGE (In years last birthday) 13	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Virlo Mills	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		15. MOTHER'S MAIDEN NAME Carrie Hunter	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Carrie H. Mills - 3412 Spellman Rd.		ADDRESS	
19. E 9531 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Asphyxia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hanging (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E 974 X II			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID INJURY OCCUR? 3412 Spellman Road		22F. HOW DID INJURY OCCUR? Hanged self	
22D. TIME OF INJURY (APPROX.) 9-8-68 12:40 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED September 9, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	

Charles J. Light

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9259

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANTHONY J. MARTIN

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☐

September 7, 1968

3:00 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION)
OR INSTITUTION

BON SECOURS HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 7, 1968

3:00 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY6. SEX
Male7. RACE
Negro8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐9. DATE OF BIRTH
7-23-194810. AGE (In years
lost birthday) 20If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.E. STREET AND NUMBER
420 Watty Ct.11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland12. CITIZEN OF
WHAT COUNTRY?
U.S.A.13. FATHER'S NAME
John Martin14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME
Anna Davis16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
No17. SOCIAL
SECURITY NO.18. INFORMANT ADDRESS
Anna D. Griffin - 420 Watty Court19. 304.9
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Intravenous Narcotism

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

323X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 9, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-13-68

24C. NAME of CEMETERY or CREMATORY

Carver Memorial Park

24D. LOCATION

(City, town, or county)

(State)

Laurel, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 11 1968

G. E. Fick

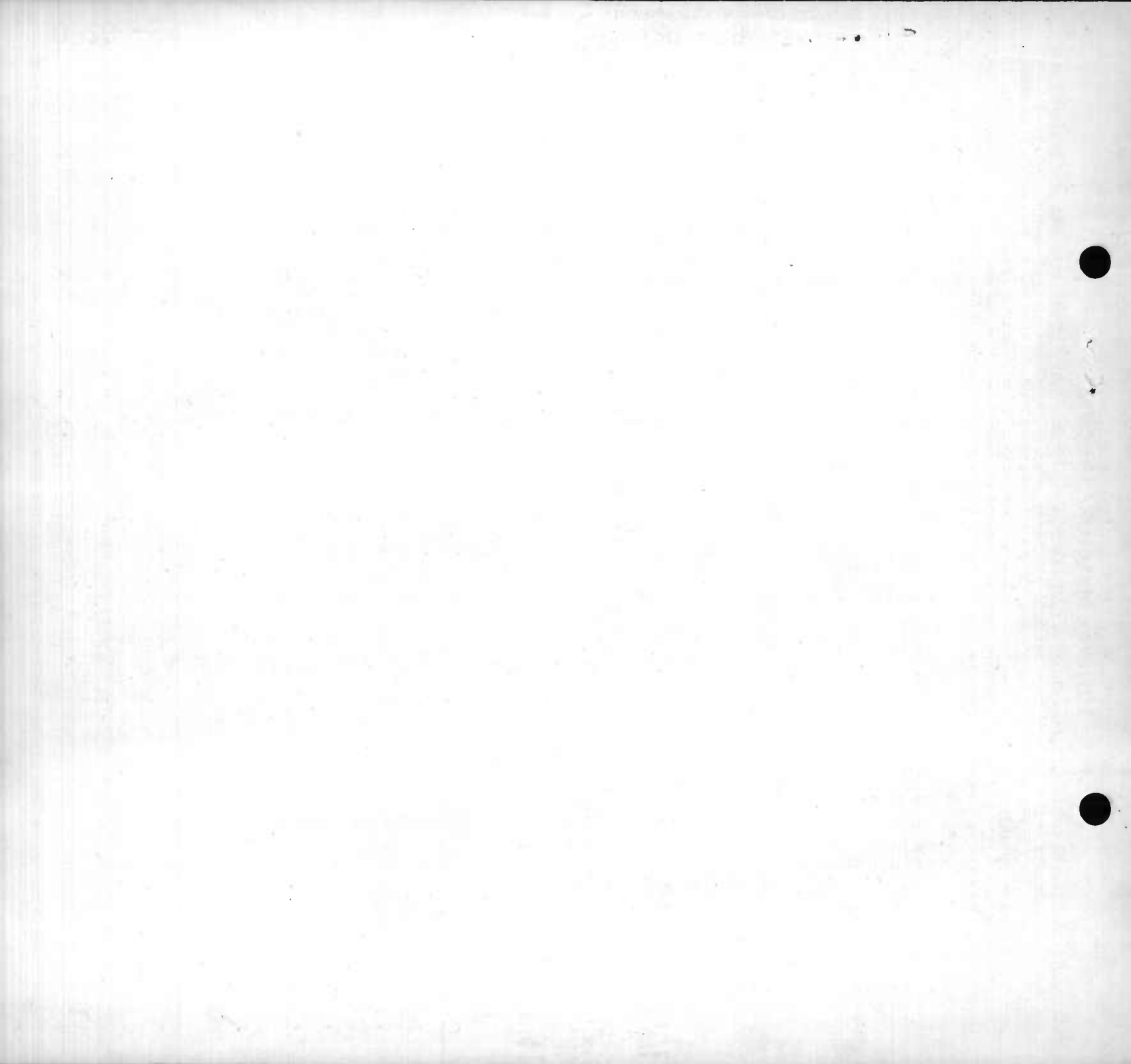
Charles R. Law 802 Madison Ave.

Handwritten signature or initials.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>WILLIAM ROBINSON</i>				2. DATE AND HOUR OF DEATH <i>9/9/68</i> <i>5</i> <i>A.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO.</i>							
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIV. OF MD. HOSP</i> <i>BALTO. MD</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>BALTO.</i>			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
5. SEX <i>M.</i>				6. RACE <i>C</i>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>3/4/14</i>				9. AGE (In years lost birthday) <i>54</i>				10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Virginia</i>			
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Clara Baxter 627 W. Conway St</i>			
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g. heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION lost.				CAUSE OF DEATH IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i> <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF: <i>PULM EMBOLUS - SUSPECTED</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>			
19A. DATE OF OPERATION <i>18/37/68</i> <i>16/8/68</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>TRAUMATIC FRACTURE OF FEMUR</i> <i>TRACHEOSTOMY</i>				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/26/68</i> 19 to <i>9/9/68</i> 19, that (I) (we) last saw the deceased alive on <i>9/9/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Harold Wilbur</i>				23B. DATE SIGNED <i>9/9/68</i>							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>9/12/68</i>				24C. NAME OF CEMETERY or CREMATORY <i>Mount Auburn</i>			
24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>											
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR <i>Charles A. Rice</i>				25C. FUNERAL DIRECTOR <i>Charles A. Rice</i>			
				25D. ADDRESS <i>66 W. Barre</i>							



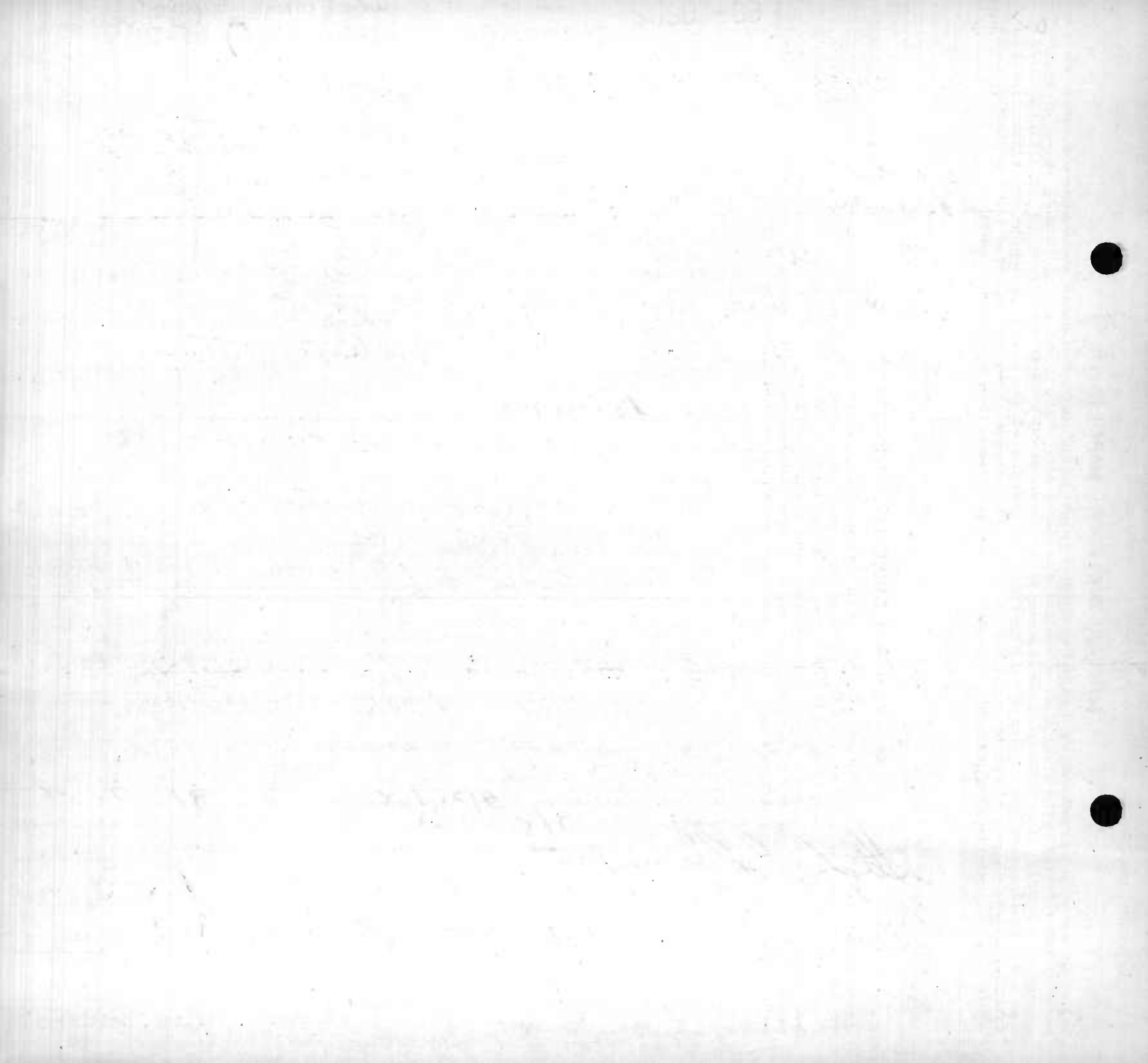
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Salisbury, Md.</i>		68- 9261		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>68- 9261</i>	
1. NAME OF DECEASED (Type or Print) <i>MICHAEL I WAYNE SMITH</i>				2. DATE AND HOUR OF DEATH <i>9/8/68 6:55 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY OF MARYLAND</i>				A. STATE <i>MD.</i>		B. COUNTY <i>WICOMICO</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>SALISBURY</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>608 DECATUR AVE.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>9/25/64</i>	9. AGE (In years lost birthday) <i>1</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CHILD</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>LOUIS WAYNE SMITH</i>				14. MOTHER'S MAIDEN NAME <i>MARY DIROCCO</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>-----</i>		17. INFORMANT (FATHER) ADDRESS <i>MR. LOUIS WAYNE SMITH, SALISBURY, MARYLAND</i>	
18. <i>347.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Ep subarachnoid hemorrhage</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>hydrocephalus</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
18. <i>344.2 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9/8/68</i> to <i>9/8/68</i> and that (I) (we) last saw the deceased alive on <i>9/8/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>John Sgnatowski M.D.</i>				23B. DATE SIGNED <i>September 8, 1968</i>		23C. ADDRESS <i>Baltimore, Maryland</i>	
23A. PHYSICIAN'S NAME (Type)		23B. DEGREE		23C. ADDRESS		23D. LOCATION (City, town, or county) (State)	
<i>John Sgnatowski, M.D.</i>		<i>MD</i>		<i>Baltimore, Maryland</i>		<i>Delmar Delaware</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>9/10/68</i>		<i>St. Stephens Cemetery</i>		<i>Delmar Delaware</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
<i>SEP 11 1968</i>		<i>Robert E. Farber</i>		<i>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</i>			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9262	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES BERNARD GROSS		2. DATE AND HOUR OF DEATH Sept. 7, 1968 7:35 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Montgomery		
FULL NAME OF HOSPITAL OR INSTITUTION U.S. Public Health Service Hosp.			C. CITY OR TOWN GAITHERSBURG		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore, Md. 21211			E. STREET AND NUMBER 4 WETSTONE DRIVE 65-00		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1913	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRON WORKER		10B. KIND OF BUSINESS OR INDUSTRY Iron industry		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Charles B. Gross		
14. MOTHER'S MAIDEN NAME Anne Downton			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1944 - 1946		
16. SOCIAL SECURITY NO. 187-61-9413			17. INFORMANT ADDRESS		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 172.7 I BRONCHOPNEUMONIA		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Melanoma metastatic to brain		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Melanoma of R. arm		6 weeks	
(C) 2 years					
190.6 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).					
19A. DATE OF OPERATION 6/13/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/25/68 19 to 9/7/68 19, that (I) (we) last saw the deceased alive on 9/8 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Sutherland, M.D.		23B. DATE SIGNED Sept. 8, 1968		23C. PHYSICIAN'S NAME (Type) JOHN C. SUTHERLAND	
23D. ADDRESS 3100 Wyman Park Dr. Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-68		24C. NAME OF CEMETERY or CREMATORY Union	
24D. LOCATION (City, town, or county) (State) Knock Pa					
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Ernest C. Gartner	
25D. ADDRESS Gaithersburg Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9263 CERTIFICATE OF DEATH

REG. NO. 68- 9263

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Jamie Johnson</u>		2. DATE AND HOUR OF DEATH <u>9-7-68</u> <u>5²⁰ A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2030 E. Lafayette Ave</u>		
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 5, 1898</u>	9. AGE (In years last birthday) <u>70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>Charles Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Maggie Borden</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Maggie Gardner</u> ADDRESS <u>2030 E Lafayette</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>CVA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>possible acute MI</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>9-5</u> 19 <u>68</u> to <u>9-7</u> 19 <u>68</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>9-7</u> 19 <u>68</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Bayani L. Manalo</u> M.D. DEGREE				23B. DATE SIGNED <u>9-7-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>BAYANI L. MANALO</u> M.D. DEGREE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>Sept 11/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Westport Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Milton E. Eliseason</u> ADDRESS <u>1129 N. Center</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT NO. 68-9264		CERTIFICATE OF DEATH		6315		9264	
1. NAME OF DECEASED (Type or Print)		LENORA JOHNSON		2. DATE AND HOUR OF DEATH		SEPTEMBER 9 1968		8:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital				A. STATE Maryland		B. COUNTY Baltimore		C. CITY OR TOWN Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 1726 E. Oliver St.			
5. SEX Female	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-07-04	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Balt. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Wilson			14. MOTHER'S MAIDEN NAME Ella			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.			17. INFORMANT Melton L. Johnson			ADDRESS 331X II			
18. 43671 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cerebral vascular accident			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours			
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 6 1968 to Sept 9 1968, that (we) last saw the deceased alive on Sept 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death.									
23A. SIGNATURE Matthew Pollack M.D.						23B. DATE SIGNED 9.9.68.		23C. PHYSICIAN'S NAME (Type) Matthew Pollack, M.D.	
23D. ADDRESS The Johns Hopkins Hospital						24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE Sept 12/68						24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A. A. County Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968						25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Joseph T. Chickens	
25D. ADDRESS 1297 Calver St									

~~XXXXXXXXXX~~



XXXXXXXXXX

XXXX

00

XXXX

XXXX

00

XXXX

XXXXXXXXXX

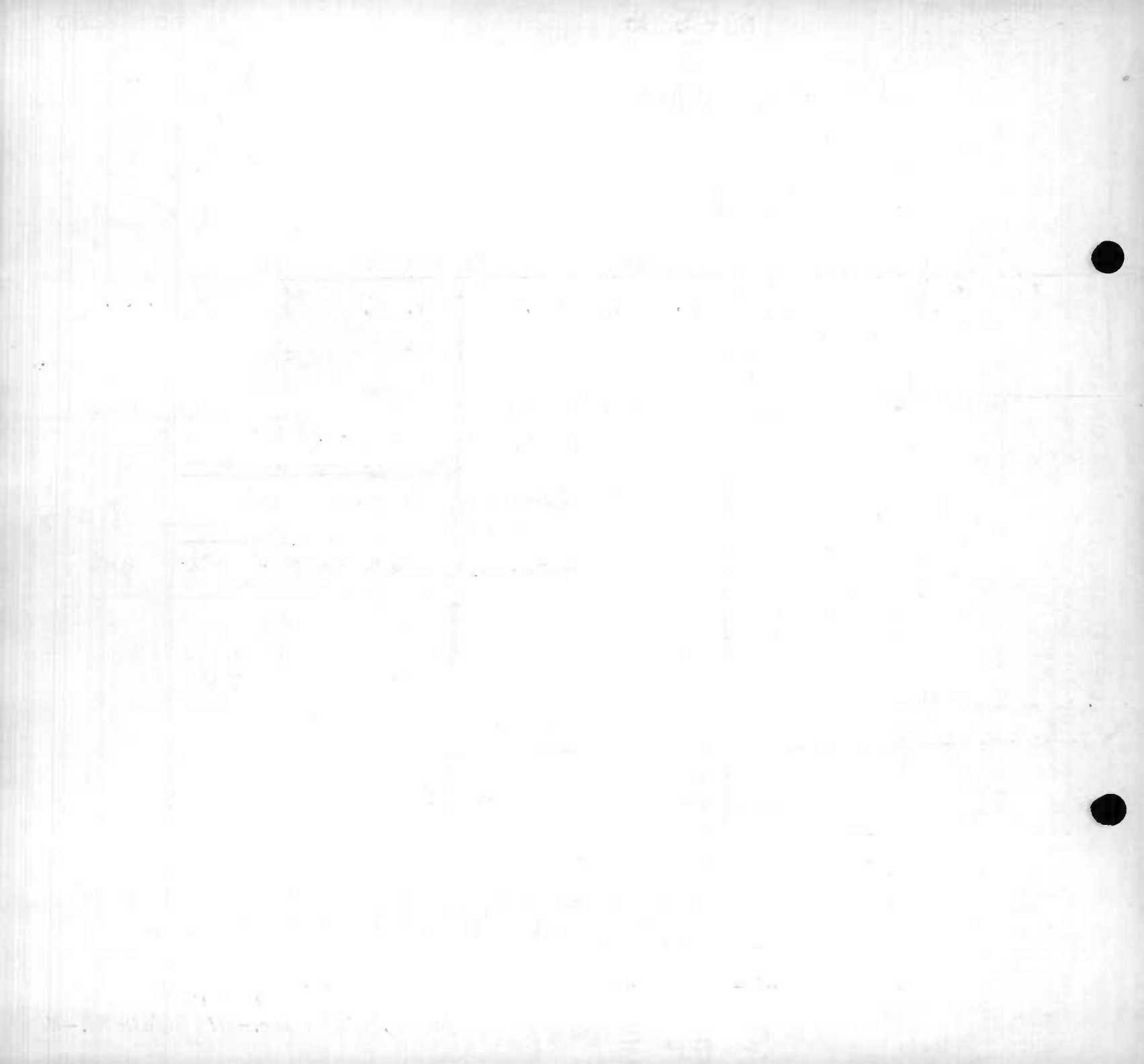
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68- 9265

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. Amy Huster</i>		2. DATE AND HOUR OF DEATH <i>9-6-68 10:32 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>11-03</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland Gen. Hospital 824 Linden Ave. Baltimore, Md. 21201</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House mother</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Md. General Hosp.</i>		8. DATE OF BIRTH <i>07-03-92</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		9. AGE (In years last birthday) <i>76</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Harvey</i>		14. MOTHER'S MAIDEN NAME <i>Bertha May Cockey</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>212 34 8944</i>		17. INFORMANT <i>Patient</i>		ADDRESS <i>As above</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>MYOCARDIAL INFARCTION</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i>		(B) <i>Connective Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: <i>ARTERIOSCLEROTIC HEART DISEASE</i>		<i>7 days</i>	
(C) <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<i>4 yrs</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>8-30</i> 19 <i>68</i> to <i>9-6</i> 19 <i>68</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>9-6</i> 19 <i>68</i> and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above. (I) (<i>We</i>) (<i>did</i>) (<i>did not</i>) view the body after death.					
23A. SIGNATURE <i>Delfa C. Gomez, M.D.</i>				23B. DATE SIGNED <i>9-6-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Delfa C. Gomez M.D.</i>				23D. ADDRESS <i>Maryland Gen. Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-10-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION <i>Baltimore, Md., and</i>		24E. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1968</i>		24F. NAME OF REGISTRAR <i>John C. Miffler Inc.</i>	
24G. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1968</i>		24H. NAME OF REGISTRAR <i>John C. Miffler Inc.</i>		24I. FUNERAL DIRECTOR <i>John C. Miffler Inc.</i>	
24J. ADDRESS <i>6415 Belair Rd. - 21206</i>		24K. ADDRESS <i>6415 Belair Rd. - 21206</i>		24L. ADDRESS <i>6415 Belair Rd. - 21206</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9266 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9266

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHNSTON, FRANK J.		SEPTEMBER 10, 1968 11:30A ^N	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL				MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5401 OLD FREDERICK RD. 21229	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05/25/99	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY DEPT BALTO CITY POLICE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHNSTON				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 1				14. MOTHER'S MAIDEN NAME MARCELLA BYRNE	
16. SOCIAL SECURITY NO. 213-30-4789				17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 434.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary embolism</i>					
(B) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <i>Congestive heart failure</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 2 19 68 to SEPTEMBER 10 19 68, that (I) (we) last saw the deceased alive on SEPTEMBER 10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. Padron</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ANSELMO PADRON				23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/14/68		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem	
24D. LOCATION (City, town, or county) (State) ELKridge Howard Co. Md					
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR E. S. Mac Nabbs		25C. FUNERAL DIRECTOR 301 Frederick Rd Baltimore Md	

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

10/10/10 10:10 AM 10/10/10 10:10 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9267 CERTIFICATE OF DEATH

REG. NO. 68- 9267

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARSON, NELLIE KATHERINE		SEPTEMBER 8, 1868 10:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 70 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				A. STATE MARYLAND B. COUNTY BALTIMORE 21224	
				C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 714 OLD NORTH POINT ROAD 53-00	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/14/07	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES L. WORTH		14. MOTHER'S MAIDEN NAME RANA F. ROGERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-56-9953		17. INFORMANT ST AGNES HOSPITAL'S RECORDS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinomatosis					
(B) Carcinoma of Left Breast DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 5 19 68 to SEPTEMBER 8 19 58, that (X) (we) lost saw the deceased alive on SEPTEMBER 8 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 09/09/68	
23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ, M.D.				23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept-12-1968		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR John J. Duda, Dundalk, Md. 21222	

CONFIDENTIAL

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

100-277-339-37

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9268

BIRTH NO.

1. NAME OF DECEASED

WILLIAM HENRY

YOUNGCOURT

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

September 7, 1968

7:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CITY HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 7, 1968

7:00 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN Edgemere

D. INSIDE CITY LIMITS?

YES ☐NO ☒

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

May 3, 1926

10. AGE (In years lost birthday)

42

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2201 Lodge Forest Drive

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF

U. S. A.

13. FATHER'S NAME

Henry Youngcourt

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Turn Forman

14B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

15. MOTHER'S MAIDEN NAME

Mary Margaret Pasiley

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

17. SOCIAL SECURITY NO.

214-22-2527

18. INFORMANT (Wife) Edgemere, ADDRESS Md. 21219

Mrs. Ruby M. Youngcourt, 2201 Lodge Forest Dr.

19.

E93210

CAUSE OF DEATH

Carbon Monoxide Poisoning

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Garage

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

2201 Lodge Forest Drive

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

Sept. 7, 1968

A.M.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Self-inflicted hose

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 7, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/11/68

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1968

25B. NAME OF REGISTRAR

Robert E. Farkas

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

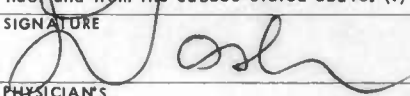
0530-10 X

WALL

Handwritten signature or initials

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9269	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mathoney, Sivill S.		2. DATE AND HOUR OF DEATH 9/9/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 36 Franklin Square Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1319 S. Carey St			
5. SEX M	6. RACE wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/3/01	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hinkle		14. MOTHER'S MAIDEN NAME ---	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Dorothy Cantrell, 1319 S. Carey St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 250.9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac standstill with Arteriosclerotic heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 260 X II		(B) DUE TO, OR AS A CONSEQUENCE OF: DIABETES		years	
(C) CHRONIC PYELONEPHRITIS				years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/5 Sept 68 to 9/9 19 68 , that (I) (we) last saw the deceased alive on 9/5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 9/10/68		23C. PHYSICIAN'S NAME (Type) Dr. Vash	
23D. ADDRESS 206 S. Gilmer St.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/13/68		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill, Maryland		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Dr. E. E. Johnson		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson ve.	

22 July 1941

Wm

General Stewart

Albuquerque, N.M.

POSTED

CHRONIC PNEUMONITIS

2/2 10/2 2/2

2/2 10/2 2/2

Robert

FUNERAL DIRECTOR: IMPORTANT

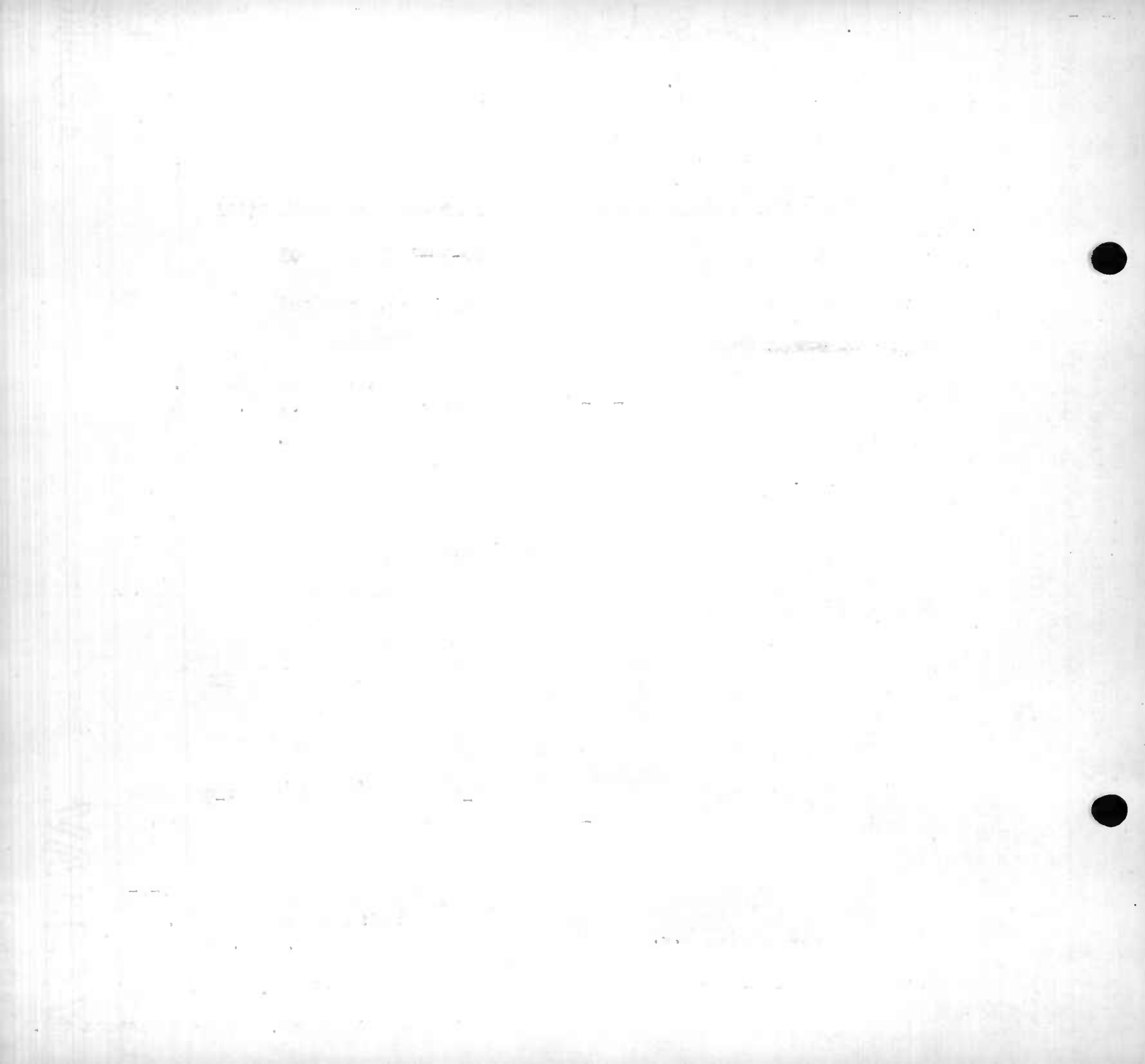
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9270
68- 9270		CERTIFICATE OF DEATH		
BIRTH NO. 530				
1. NAME OF DECEASED (Type or Print) JACK. J. SMITH.		2. DATE AND HOUR OF DEATH 11th SEPT. 1968 5.50 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL. 9-13-68		A. STATE MARYLAND 21229		
<div style="position: relative; height: 100px;"> <div style="position: absolute; top: 0; left: 0; right: 0; bottom: 0; background-color: black; color: white; font-size: 2em; font-weight: bold; text-align: center; line-height: 1;"> CERTIFICATE AMENDED </div> </div>		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4104 GLEN HUNT. RD.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-3-13 8-31-12	9. AGE (In years lost birthday) 55 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PURCHASING AGENT		10B. KIND OF BUSINESS OR INDUSTRY TRANSIT. Co.		11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? AMERICA (U.S.A.)				
13. FATHER'S NAME SMITH		14. MOTHER'S MAIDEN NAME AGATHA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO.		17. INFORMANT THOMAS. J. SMITH (SON) 4104, Glen Hunt Rd. Balt. MD. 21229.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SUB-ARACHNOID. HAEMORRHAGE. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 5 DAYS		
19. DATE OF OPERATION 9/11/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 9/5 19 68 to 9/11 19 68 , that (I) (we) last saw the deceased alive on 9/11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. H. Mather.		23B. DATE SIGNED 9/11/68		
23C. PHYSICIAN'S NAME (Type) JOHN. H. MATHER.		23D. ADDRESS M.B.B.S. 5308-D. LEITH RD., BALTIMORE. MD. 21212.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR WITZKE. 4104, EDWARDS. AVE.

Corrected from Birth Record Balto. City Cert. # A-90704 Born 8-3-13 j1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-652				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9271	
BIRTH NO.				68-9271			
1. NAME OF DECEASED (Type or Print)		Adam J. France		2. DATE AND HOUR OF DEATH		9/9/68 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND B. COUNTY			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4940 EASTERN AVENUE 21224			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-30-1887	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ignatious France				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-6292		17. INFORMANT RECORDS: BCH: 4940 EASTERN AVE. BALTO., MD. 21224		ADDRESS	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE C U A DUE TO, OR AS A CONSEQUENCE OF: (B) A S C U D DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-9 19 66 to 9-9 19 68, that (I) (we) last saw the deceased alive on 9-9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Paul Kalkut, M.D.				23B. DATE SIGNED 9-9-68			
23C. PHYSICIAN'S NAME (Type) PAUL KALKUT M.D.				23D. ADDRESS BCH: 4940 EASTERN AVE. BALTO., MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12-1968		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9272

BIRTH NO.

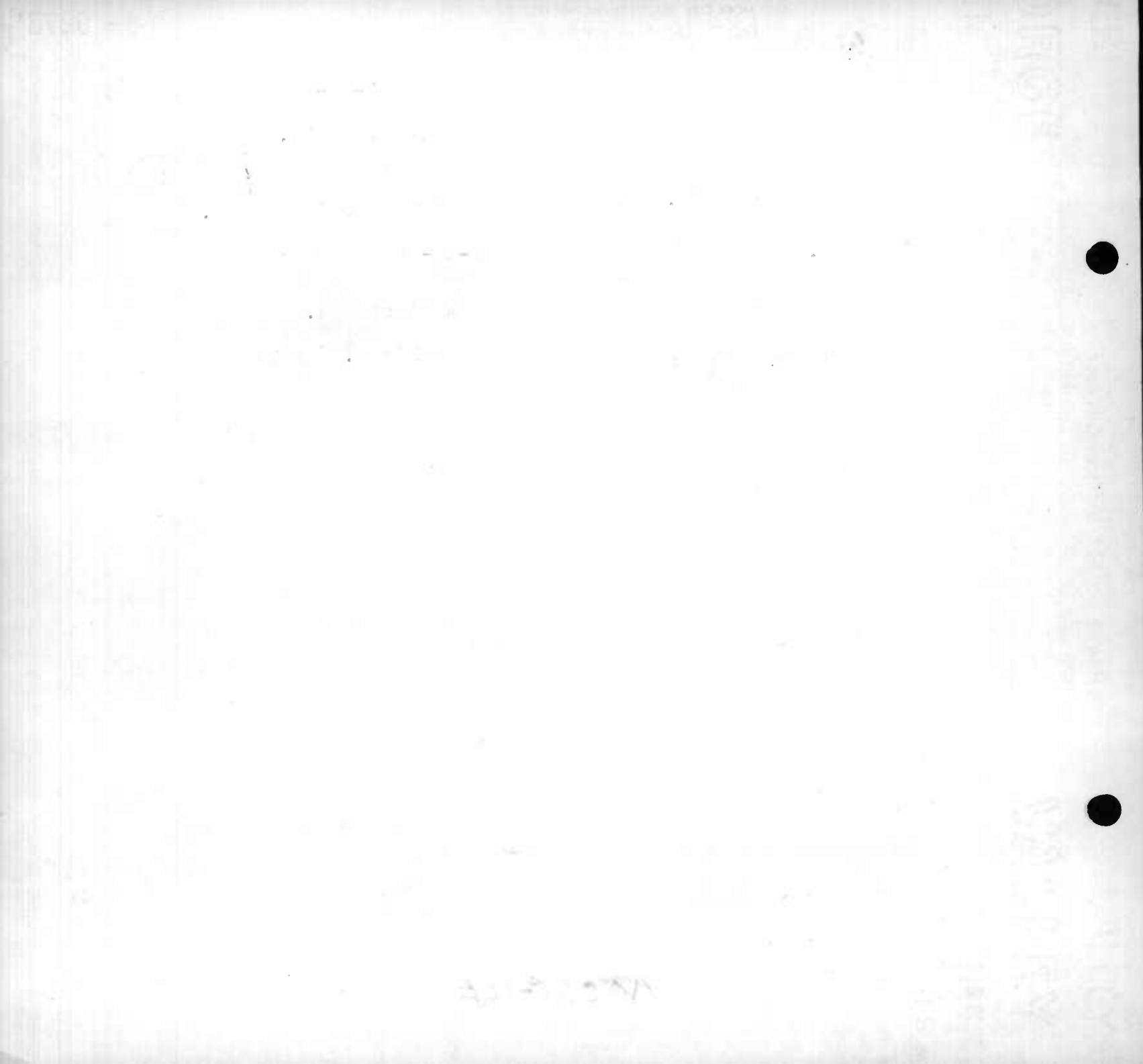
1. NAME OF DECEASED (Type or Print) CALVIN Lambert JACKSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 10, 1968 10:10 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour September 10, 1968 10:10 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 5, 1949		10. AGE (In years lost birthday) 19 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Richwood, West Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Jackson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant	
15. MOTHER'S MAIDEN NAME Alice Wahl		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 219-50-5440		18. INFORMANT Mrs. Alice Jackson	
19. CAUSE OF DEATH E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot Wound of Abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION E981X		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2002 Fountain St. 1-03		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8/21/68 9:40 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? subj. was shot in abdomen	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 9/10/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-1968	
24C. NAME of CEMETERY or CREMATORY Crest Lawn		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	

James R. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-9273</u>
BIRTH NO. <u>68-15497</u>		68- 9273 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>John Hargrove</u>		2. DATE AND HOUR OF DEATH <u>8-19-68</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		A. STATE <u>Baltimore Md.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>730 Ashburton St. # 21216</u>		B. COUNTY		
		C. CITY OR TOWN <u>Baltimore</u>		
		INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>2910 Garrison Blvd.</u>		
5. SEX <u>Male</u>	6. RACE <u>N.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-68</u>	9. AGE (In years last birthday) <u>Newborn</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>
13. FATHER'S NAME <u>John Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Lelia R. Hargrove</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u>
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Island family</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION				
18. <u>776X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dahlia Quijada</u>		23B. DATE SIGNED <u>8/19/68</u>		23C. PHYSICIAN'S NAME (Type) <u>DAHLIA QUIJADA MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremated</u>		24B. DATE <u>8-29-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>MORRIS</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tanaka</u>		25C. FUNERAL DIRECTOR <u>Baltimore Md</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9274 4
BIRTH NO. 68- 16121		68- 9274		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) Baby Girl Williams		2. DATE AND HOUR OF DEATH 8/23/68 1005 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE U.S. Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. 44		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 719 McCabe Ave.		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/68	9. AGE (In years last birthday) 11 29
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Margaret Carla Williams		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. 733.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest (B) Prematurity (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 11 hr.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 433.0 II Y.S.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from August 23 1968 to August 23 1968, that (I) (we) last saw the deceased alive on August 23 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Andrew Sun M.D.		23B. DATE SIGNED 8/23/68		23C. PHYSICIAN'S NAME (Type) ANDREW SUN M.D. M.P.H.
23D. ADDRESS Union Memorial Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated	24B. DATE 8-29-68	24C. NAME OF CEMETERY or CREMATORY Medical Examiners Office	24D. LOCATION Balto.	(State) Md
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968	25B. NAME OF REGISTRAR Robert E. Farber	25C. FUNERAL DIRECTOR 9274		

These names are listed

F. N.

John
Johnson

8/23/28

Baltimore

Thurgood Marshall

Charles W. Marshall

President

April 23 28
April 23 28

Andrew S. M.D.

ANDREW S. M.D. MPH

These names are listed

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
MAUDE ANDERSON		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> 9 6 68 12:30a M.		Month Day Year Hour September 6, 1968 12:30 a M.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
90 Bolton Hill Nursing Home		Maryland		A. STATE		B. COUNTY	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. SOCIAL SECURITY NO.		16. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
17. DATE OF DEATH		18. DATE PRONOUNCED DEAD		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
20. DATE OF BIRTH		21. AGE (In years last birthday)		22. BIRTHPLACE (State or foreign country)		23. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
24. FATHER'S NAME		25. MOTHER'S MAIDEN NAME		26. SOCIAL SECURITY NO.		27. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
28. DATE OF DEATH		29. DATE PRONOUNCED DEAD		30. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
31. DATE OF BIRTH		32. AGE (In years last birthday)		33. BIRTHPLACE (State or foreign country)		34. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
35. FATHER'S NAME		36. MOTHER'S MAIDEN NAME		37. SOCIAL SECURITY NO.		38. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
39. DATE OF DEATH		40. DATE PRONOUNCED DEAD		41. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
42. DATE OF BIRTH		43. AGE (In years last birthday)		44. BIRTHPLACE (State or foreign country)		45. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
46. FATHER'S NAME		47. MOTHER'S MAIDEN NAME		48. SOCIAL SECURITY NO.		49. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
50. DATE OF DEATH		51. DATE PRONOUNCED DEAD		52. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
53. DATE OF BIRTH		54. AGE (In years last birthday)		55. BIRTHPLACE (State or foreign country)		56. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
57. FATHER'S NAME		58. MOTHER'S MAIDEN NAME		59. SOCIAL SECURITY NO.		60. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
61. DATE OF DEATH		62. DATE PRONOUNCED DEAD		63. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
64. DATE OF BIRTH		65. AGE (In years last birthday)		66. BIRTHPLACE (State or foreign country)		67. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
68. FATHER'S NAME		69. MOTHER'S MAIDEN NAME		70. SOCIAL SECURITY NO.		71. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
72. DATE OF DEATH		73. DATE PRONOUNCED DEAD		74. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
75. DATE OF BIRTH		76. AGE (In years last birthday)		77. BIRTHPLACE (State or foreign country)		78. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
79. FATHER'S NAME		80. MOTHER'S MAIDEN NAME		81. SOCIAL SECURITY NO.		82. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
83. DATE OF DEATH		84. DATE PRONOUNCED DEAD		85. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
86. DATE OF BIRTH		87. AGE (In years last birthday)		88. BIRTHPLACE (State or foreign country)		89. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
90. FATHER'S NAME		91. MOTHER'S MAIDEN NAME		92. SOCIAL SECURITY NO.		93. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
94. DATE OF DEATH		95. DATE PRONOUNCED DEAD		96. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
97. DATE OF BIRTH		98. AGE (In years last birthday)		99. BIRTHPLACE (State or foreign country)		100. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
101. FATHER'S NAME		102. MOTHER'S MAIDEN NAME		103. SOCIAL SECURITY NO.		104. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		Hosp. Records	
105. DATE OF DEATH		106. DATE PRONOUNCED DEAD		107. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9 6 68		September 6, 1968		Arteriosclerotic cardiovascular disease		1 hour	
108. DATE OF BIRTH		109. AGE (In years last birthday)		110. BIRTHPLACE (State or foreign country)		111. CITIZEN OF WHAT COUNTRY?	
2/3/88		80		Pennsylvania		U.S.A.	
112. FATHER'S NAME		113. MOTHER'S MAIDEN NAME		114. SOCIAL SECURITY NO.		115. INFORMATION ADDRESS	
James Kocher		Mary GUNTZ		219-07-5485 D		H	

X

X

WALTON & SONS

WALTON & SONS

WALTON & SONS

WALTON & SONS

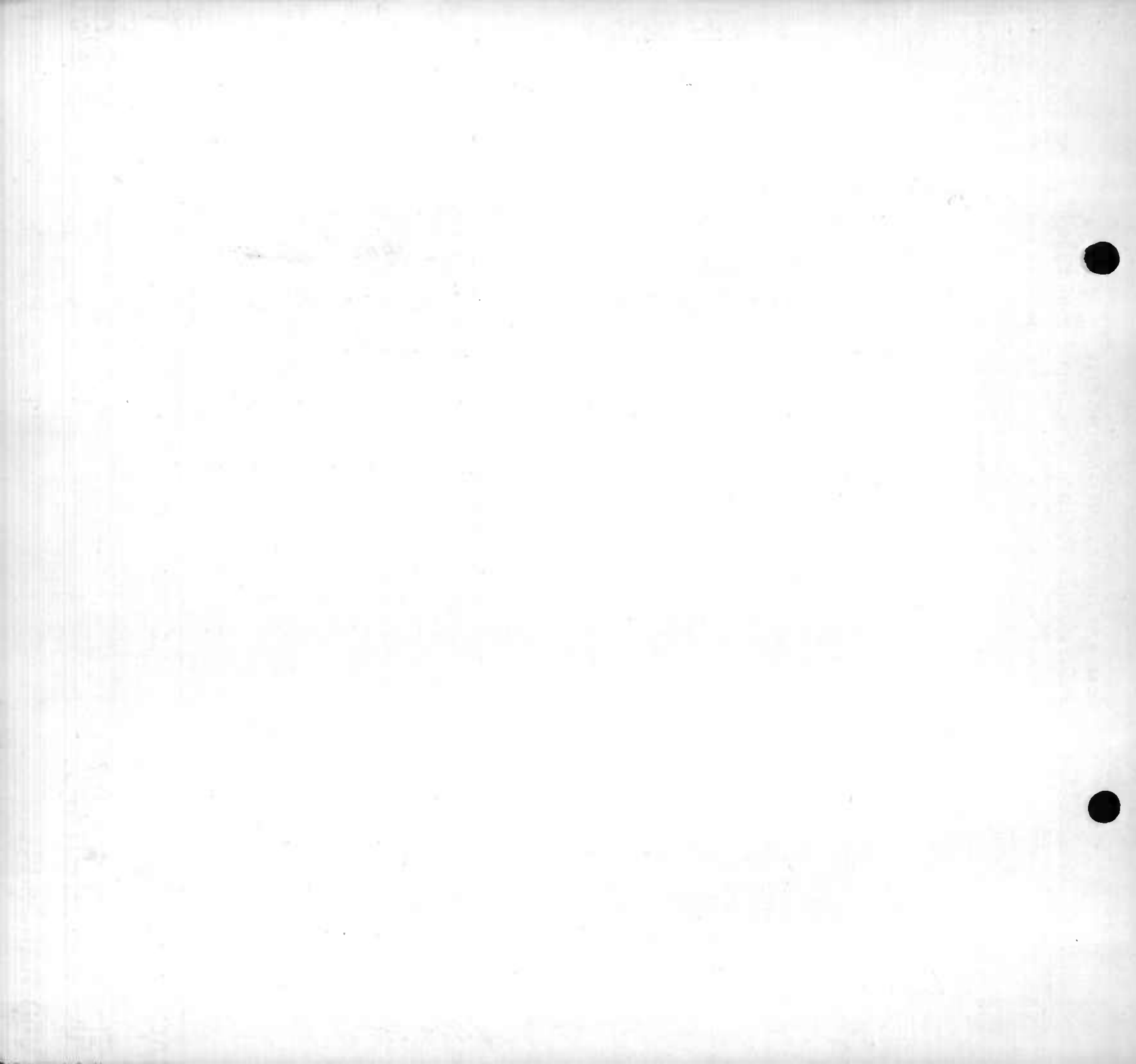
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9276 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT
REG. NO. 68- 9276

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">CARVER SUBELTA</div>		2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">SEP 10-1968 6.30 P.M.</div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center; font-size: 1.2em;">LUTHERAN HOSPITAL OF MARYLAND</div>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2117 N. LONGWOOD ST.</u>	
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1905</u>	9. AGE (In years last birthday) <u>63 yr.</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PLYMOUTH N.C.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>FRANCES</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN MOBLEY 2117 Longwood St</u>	
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEP-5-1</u> 19 <u>68</u> to <u>SEP 10</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>SEP 10</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jorge Garcia M.D.</u>				23B. DATE SIGNED <u>SEP 10, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>JORGE GARCIA M.D.</u>				23D. ADDRESS <u>LUTHERAN HOSPITAL OF MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/15/68</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Anthony</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>John P. Taylor 6383</u>			



B-535

68- 9277 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9277

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOROTHY MEACH BENTON				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 10, 1968 UNK M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1735 Mc Culloh Street				3. DATE PRONOUNCED DEAD Month Day Year Hour September 10m 1968 5:05 A. M.	
6. SEX female		7. RACE negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-26-1933				10. AGE (In years last birthday) 35 (?)	
11. BIRTHPLACE (State or foreign country) Baltimore md				12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				15. MOTHER'S MAIDEN NAME Germette Meach	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO.	
19. E966X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Multiple Stab Wounds (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				18. INFORMANT Germette Meach 16 E. Lombard St. ADDRESS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2					
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
21. AUTOPSY? (Yes or No) Yes					
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1735 McCulloh Street				14-02	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 9/10/68 UNK m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? subj. stabbed during altercation					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/10/68 ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-68		24C. NAME OF CEMETERY or CREMATORY Int'l. Mt. Carmel	
24D. LOCATION (City, town, or county) (State) Baltimore Md 21206		25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968			
25B. NAME OF REGISTRAR Robert E. Sisk		25C. FUNERAL DIRECTOR Clayton Wilson & Son			

1-25-25

James M. [unclear]
[unclear] [unclear]
[unclear] [unclear]

James M. [unclear]

James M. [unclear]
[unclear] [unclear]

MAILED 10 1925

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9278

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9278

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HENRY SMITH

2. DATE AND HOUR OF DEATH

9-7-68 12¹⁵ A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Melchor Nursing Home

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MO

BALTO.

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

7-05

NO ☐

E. STREET AND NUMBER

817 N. Durham St.

5. SEX

M

6. RACE

N

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-1-1899

9. AGE (In years
lost birthday)

69

If Under 1 Yr.

Months

Days

Hours

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

unemployed

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

FLA.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL
SECURITY NO.

312-46-2217

17. INFORMANT

Annie Smith

ADDRESS

same

1. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

C.A. of Lung

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) CHRONIC EMPHYSEMA

DUE TO, OR AS A CONSEQUENCE OF:

years

(C).....

MEDICAL CERTIFICATION

163X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐
WorkNot White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-13-1968 to 9-7-1968,
that (I) (we) last saw the deceased alive on 9-7-1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Cesar Valle Cervero

DEGREE

Attending ☒
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

9-7-68

23C. PHYSICIAN'S
NAME (Type)

CESAR VALLE CAVERO

DEGREE

23D. ADDRESS

8624 Liberty Rd

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-10-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1968

25B. NAME OF REGISTRAR

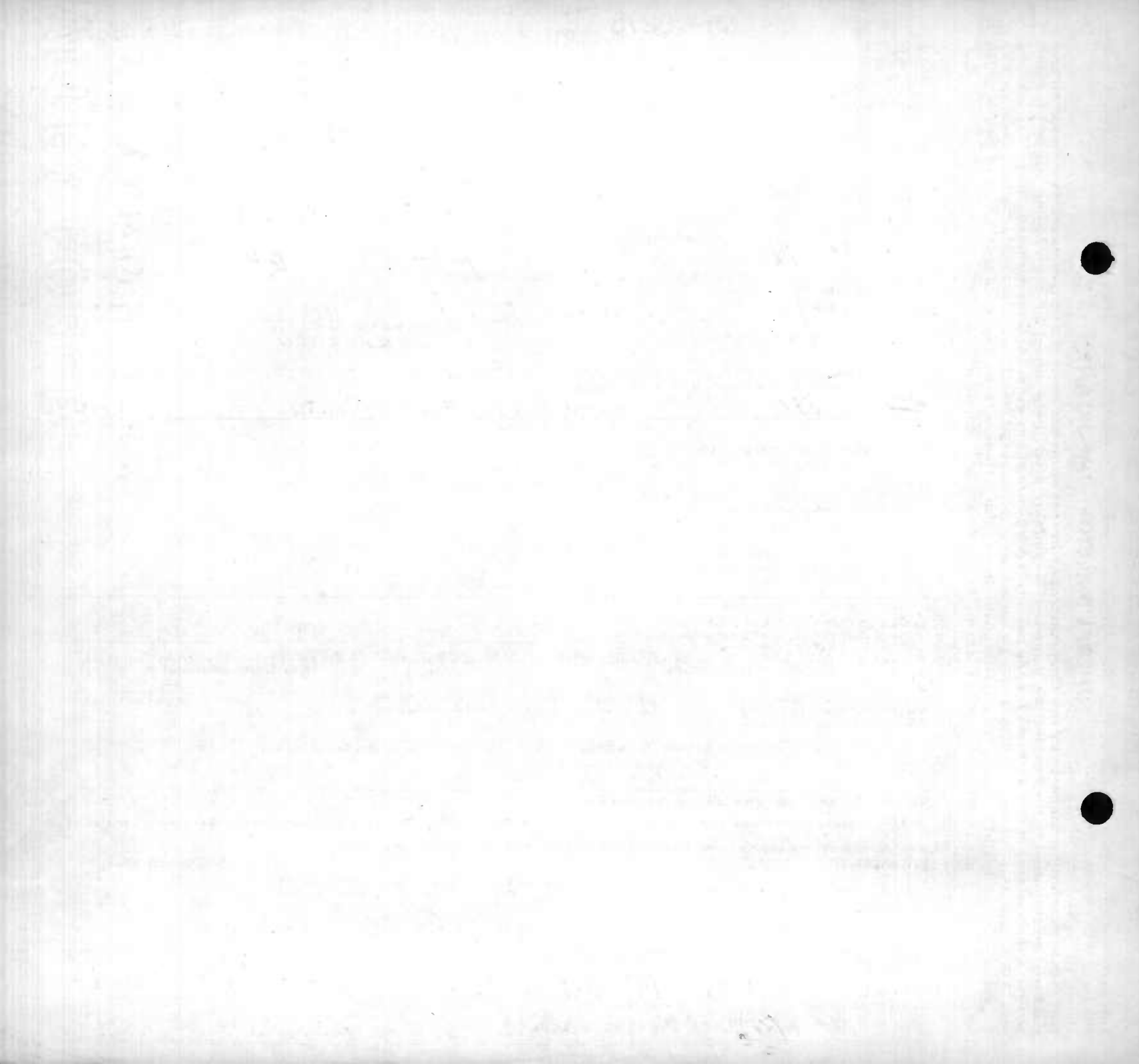
Robert E. Johnson

25C. FUNERAL DIRECTOR

E. Roy O. Wilson

ADDRESS

Jef.



1
L-200

68- 9279 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9279

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CAREY LEWIS

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

9 10

68

2:06 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 617 Ensor St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 10, 1968

2:06 p. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

B. MARRIED ☒ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

Colored

WIDOWED ☒DIVORCED ☐

Balto.

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Nov 16 - 1911

56

E. STREET AND NUMBER

617 Ensor St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. 68-9279-1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cirrhosis
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 11, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

WALBURN & CO. LTD.

25/10/1910

WALBURN & CO. LTD.

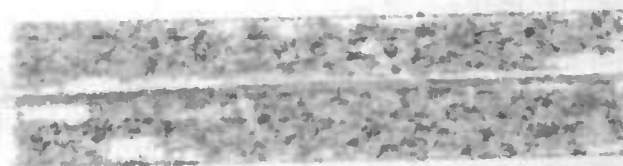
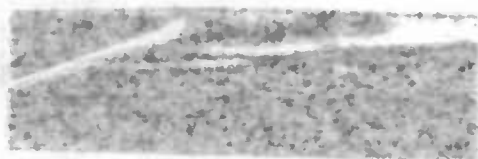
WALBURN & CO. LTD.

WALBURN & CO. LTD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				68- 9280			
1. NAME OF DECEASED (Type or Print) <i>Georgia Nohlee</i>				2. DATE AND HOUR OF DEATH <i>September 7, 1968 8 P.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Maryland General Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i>				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Maryland General Hospital</i>				C. CITY OR TOWN <i>BALTIMORE</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <i>8545 Pulaski Highway</i>							
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/8/1890</i>	9. AGE (In years lost birthday) <i>78</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>				11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>JOHN CANNON</i>				14. MOTHER'S MAIDEN NAME <i>NORA LEE</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>				17. INFORMANT <i>Miss Hill</i>			
				ADDRESS <i>PARK HILL Nursing Home</i>							
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>ACUTE MYOCARDIAL INFARCTION</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ACUTE MYOCARDIAL INFARCTION</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <i>9-28-68</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>Sept 6</i> 19 <i>68</i> to <i>Sept 7</i> 19 <i>68</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>Sept 7</i> 19 <i>68</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Carol Lee Koski MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>Sept 7, 1968</i>			
23C. PHYSICIAN'S NAME (Type) <i>CAROL LEE KOSKI</i>				23D. ADDRESS <i>Maryland General Hospital</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>9-10-1968</i>				24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>			
				24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md</i>							
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 11 1968</i>				25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>				25C. FUNERAL DIRECTOR <i>Lassahn Funeral Home 7401 Bealir Road</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9281	
<div style="display: flex; justify-content: space-between;"> 68- 9281 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) John M. Sahlman </div> <div> 2. DATE AND HOUR OF DEATH 9- 9-1968 </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 90 </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gould Convs. Belair Road </div> </div>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE Md. </div> <div> B. COUNTY 26 </div> </div>		
5. SEX Male			6. RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10B. KIND OF BUSINESS OR INDUSTRY Baltimore Transit		11. BIRTHPLACE (State or foreign country) Baltimore Co. Maryland	
13. FATHER'S NAME August F. Sahlman			14. MOTHER'S MAIDEN NAME Margaret Schaeffer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 213-05-9186		17. INFORMANT Mrs Margaret Swenson 5913 Eurith Avenue	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Stroke </div> <div> (B) Cerebrovascular Insufficiency DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D. </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 2 wks 2 yrs					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 722.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/8 Jan 1966 to 9/9/68 19 that (I) (we) last saw the deceased alive on 9/8 Jan 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. M. Baumgardner				23B. DATE SIGNED 9/10/68	
23C. PHYSICIAN'S NAME (Type) G. M. Baumgardner				23D. ADDRESS Baltimore 21237	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-1968		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ADDRESS	
Baltimore		Co.		Md.	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 11 1968 25B. NAME OF REGISTRAR Robert E. Sahlman					
25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road					

Central Atlantic
Colonial Building
A.S.C.V.D.

1/18 Jan 1902

1/18/02

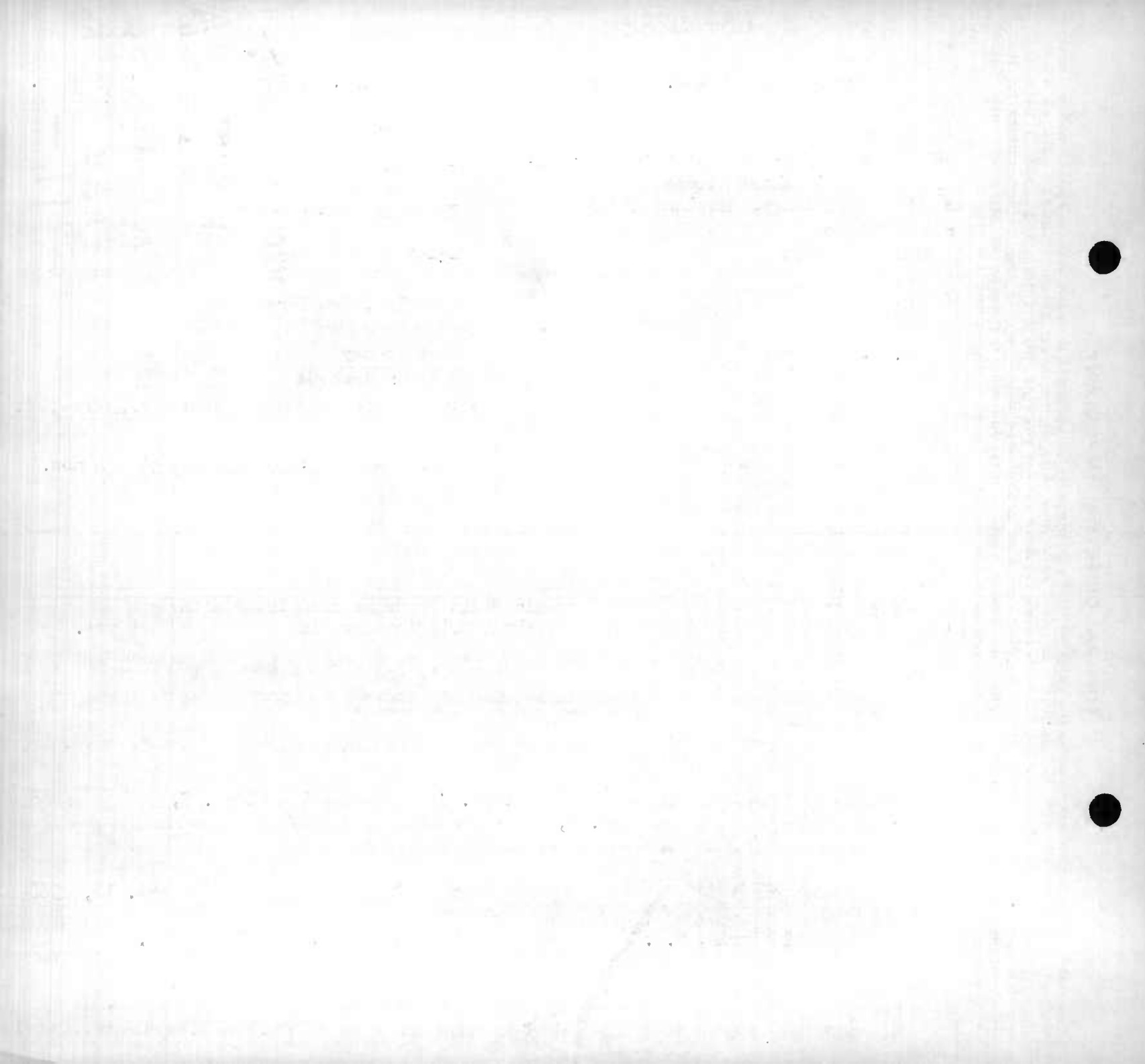
G. M. BARNARD
Box 31231

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9282 CERTIFICATE OF DEATH

REG. NO. 68- 9282

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Reverend Charles J. Rooney		2. DATE AND HOUR OF DEATH Sept. 9, 1968 9:55 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New York B. COUNTY V-29		C. CITY OR TOWN Brooklyn D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 21 The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215		E. STREET AND NUMBER 75 Lewis Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-93	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, New York	
13. FATHER'S NAME Mr. Owen Rooney		14. MOTHER'S MAIDEN NAME Anne Rooney		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO.		17. INFORMANT : Records ADDRESS Seton Institute, 6400 Wabash Av., Balto, Md.	
18. 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Carcinoma of liver (primary ?) DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Chronic Brain Syndrome associated with cerebral arteriosclerosis		5 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Sept. 7, 1967 to Sept. 9, 1968 , that (1) (we) last saw the deceased alive on Sept. 9, 1968 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE SR Amye		DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept. 10, 1968	
23C. PHYSICIAN'S NAME (Type) Raphael Nigrin, M.D.		23D. ADDRESS 6400 Wabash Ave., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9/13/68	24C. NAME OF CEMETERY or CREMATORY ST. JOSEPH'S CEMETERY		24D. LOCATION (City, town, or county) (State) PRINCETON, N. J.	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. ADDRESS 108 W. North Av., Cityl	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9283

BIRTH NO. 18-10844

1. NAME OF DECEASED
(Type or Print)

TINA WINTERS

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

September 9, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

(DOA)

South Baltimore General Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 9, 1968

10:25 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

7/8/68

10. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3

E. STREET AND NUMBER

422 Arsan Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Donald Winters

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Janet Durm

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. 3819 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Bilateral otitis media
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

391.2 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 9, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

9/11/68

24C. NAME of CEMETERY or CREMATORY

Glen Haven Cemetery

24D. LOCATION (City, town, or county)

Glen Burnie, Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1968

25B. NAME OF REGISTRAR

Robert E. Fink

25C. FUNERAL DIRECTOR

Raymond C. Fink

ADDRESS

Glen Burnie, Md.

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9284

BIRTH NO.

REG. NO.

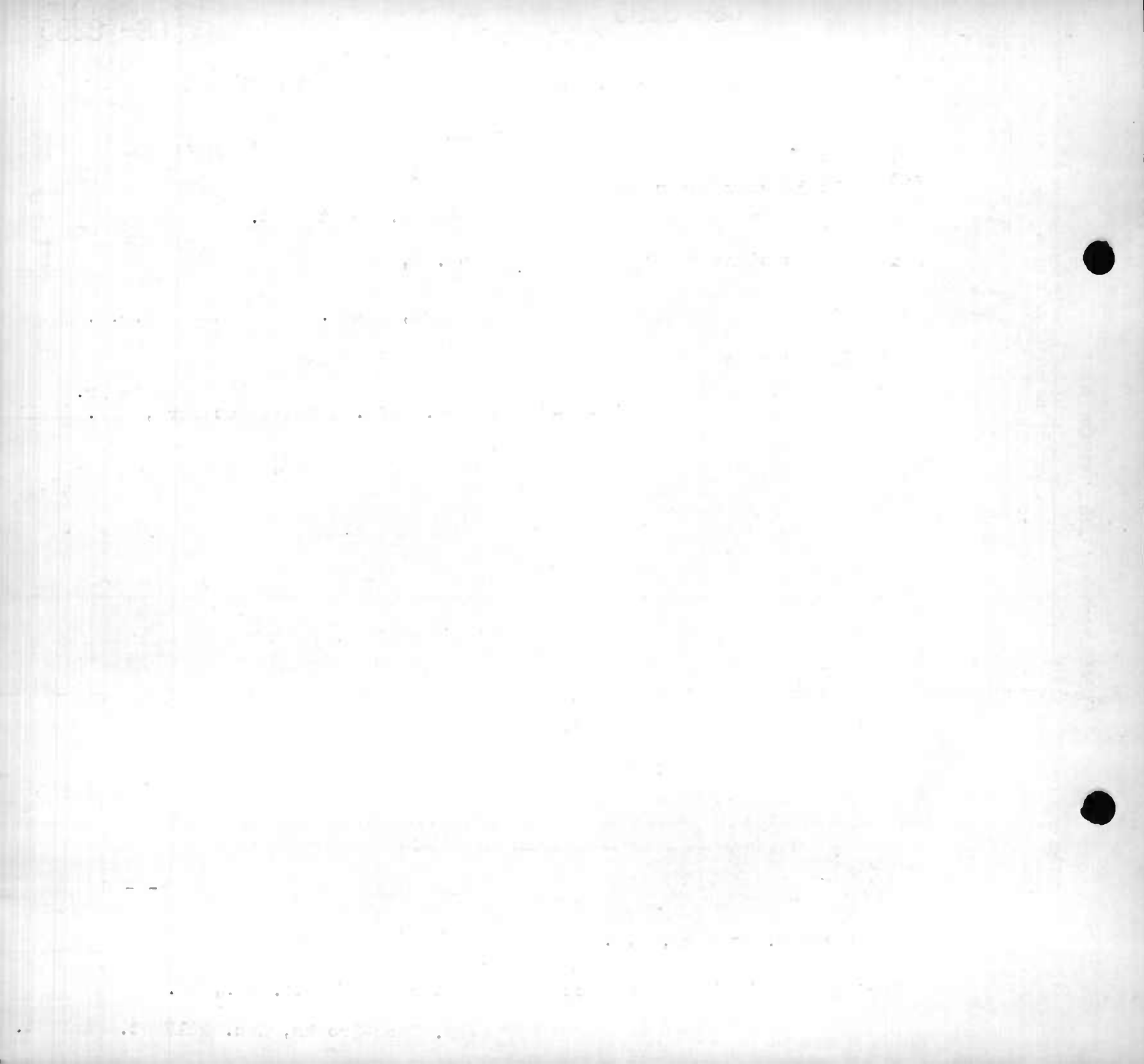
1. NAME OF DECEASED (Type or Print) RUSSELL LEWIS POTTS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 9, 1968 Hour 3:18 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 9, 1968 3:18 P.M.	
6. SEX male	7. RACE white	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Frederick	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Frederick D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Nov. 8, 1932		10. AGE (In years last birthday) 35	
11. BIRTHPLACE (State or foreign country) Frederick		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		14B. KIND OF BUSINESS OR INDUSTRY Md. State Rd. Comm.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Korean Conflict		15. MOTHER'S MAIDEN NAME Daisy E. Lamb	
17. SOCIAL SECURITY NO. 217 28 1495		18. INFORMANT Mrs. Catherine Potts, 204 W. 5th St. Frederick, Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Other significant conditions contributing to the death but not related to the terminal disease or condition given in part 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9/9/68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Worker at construction site - was struck by caterpillar scraper.	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Interstate 95 - 1 mile W. of Dorsey, Maryland.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9/9/68 2:45 P. M.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Worker at construction site - was struck by caterpillar scraper.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/10/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 13, 1968	
24C. NAME OF CEMETERY or CREMATORY Mount Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Frederick Frederick Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR Robert E. Farley, Jr.	
25C. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25D. ADDRESS Frederick, Maryland	

8591.21.1992

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

68- 9285 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9285	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Fraker, Viola Buhrman				September 8, 1968 10 ⁰⁰ P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium				A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 429 E. Preston St.	
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1889	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) York, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Josiah Buhrman		
14. MOTHER'S MAIDEN NAME Mamie Folke			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-09-8067B			17. INFORMANT Mrs. Eliz. Buhrman Rockford, Ill. 61111		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 4-36191			CAUSE OF DEATH Uremia		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dehydration		
			(B) DUE TO, OR AS A CONSEQUENCE OF: Multiple strokes		
			(C) Urinary Tract Infection		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 334X II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30/1968 to 8/9/1968 , that (I) (we) last saw the deceased alive on 8/1/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 9/9-68	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.				23D. ADDRESS 4900 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/68		24C. NAME OF CEMETERY or CREMATORY Prospect Hill Cemetery	
24D. LOCATION Balto. Co., Md.		24E. NAME OF REGISTRAR Robert E. Tarkenton			
25A. DATE REC'D BY HEALTH DEPT. SEP 11 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.	
25D. ADDRESS 1217 St. Paul St.					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9286

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIE COAD JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 6, 1968 2:50 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1418 E. Preston Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 6, 1968 2:50 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-8-21		10. AGE (In years lost birthday) 46	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPARROWS POINT		14B. KIND OF BUSINESS OR INDUSTRY SPARROWS POINT	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 213-20-3611	
18. INFORMANT SALLIE AUSTIN		ADDRESS 1629-71. Bond St	
19. 303.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Auto alcoholism		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Auto alcoholism	
20. DATE OF OPERATION 9		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 7, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-11-68	
24C. NAME OF CEMETERY or CREMATORY MT-AUBURN		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Williams	
25C. FUNERAL DIRECTOR JOSEPH KNIGHT		ADDRESS 1639 N. Broadway	

GEORGE CLARK

SALES LYLES

GEORGE CLARK

NO

GEORGE CLARK

GEORGE CLARK

GEORGE CLARK

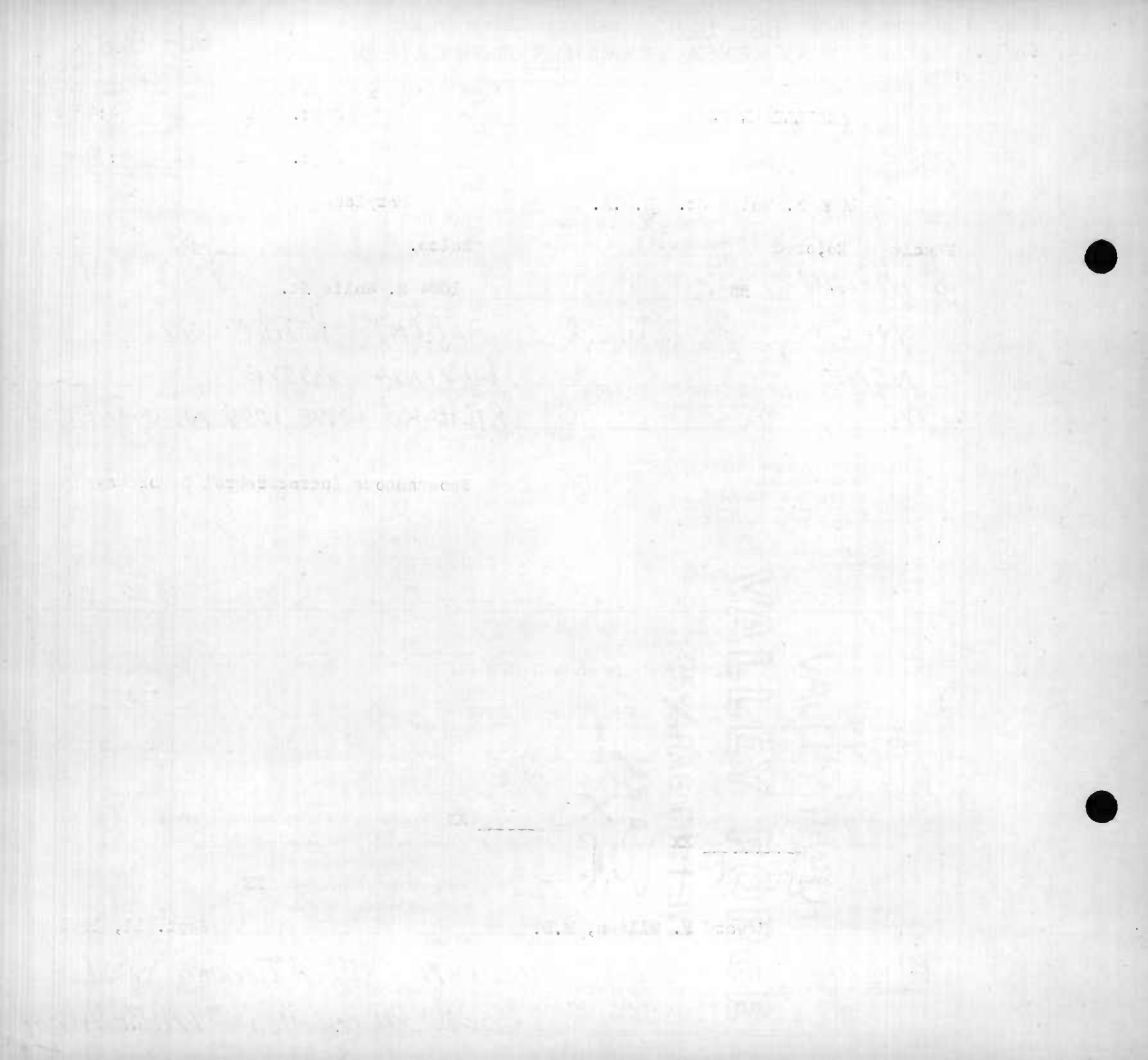
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9287

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ARDELLIA LOWE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Sept. 10 68 4:40 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1004 N. Wolfe St. D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour Sept. 10 68 4:40 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY			
6. SEX Female	7. RACE Colored	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 8-17-1914		10. AGE (In years last birthday) 53	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 1004 N. Wolfe St.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME LUVINIA MOYE
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	18. INFORMANT RICHARD LOWE 1004 N. WOLFE ST
19. 433.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Spontaneous intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) YES	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Sept. 11, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-14-68	24C. NAME OF CEMETERY or CREMATORY MT AUBURN	24D. LOCATION (City, town, or county) (State) BALTIMORE MD
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968	25B. NAME OF REGISTRAR Robert E. [illegible]	25C. FUNERAL DIRECTOR ADDRESS JOSEPH KNIGHT 1639 N. BROADWAY	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9288

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BETTY WALKER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 9 10 68		Hour 9:55 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles General Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 10, 1968		Hour 9:55 P.
6. SEX Female		7. RACE Colored	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-16-1906		10. AGE (In years lost birthday) 62	11. BIRTHPLACE (State or foreign country) ARK.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GREEN BARK		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.
18. INFORMANT JACIE WALKER		19. ADDRESS PASADENA Md.		20. CAUSE OF DEATH Hypertensive cardiovascular disease
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 443X II		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		23. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:
24A. DATE OF OPERATION 2		24B. CONDITION FOR WHICH OPERATION WAS PERFORMED		24C. AUTOPSY? (Yes or No) YES
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. DATE SIGNED September 11, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIED		24B. DATE 9-17-68		24C. NAME OF CEMETERY or CREMATORY MT CALVARY
24D. LOCATION (City, town, or county) (State) a a COUNTY Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 12 1968		24F. NAME OF REGISTRAR JOSEPH KNIGHT
24G. FUNERAL DIRECTOR 1639 N BROADWAY		24H. ADDRESS		

A.A.

X

12-16-1912

GREEN BARK

U.S.A.

ARK.

UNKNOWN

JACIE WALKER

NO

Shirley

ARK.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9289 CERTIFICATE OF DEATH

REG. NO. 68- 9289

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY KELLNER		SEPT. 8 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION BALTO. CITY HOSP			A. STATE MD. BALTO. 53-00 B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN DUNOAK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 7506 NEW BATTLE GROVE CIRCLE					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/18/08	9. AGE (In years last birthday) 59
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM ZORN			14. MOTHER'S MAIDEN NAME MARTHA KAUFFMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NA		16. SOCIAL SECURITY NO.		17. INFORMANT CHARLES KELLNER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, as heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 410.01 DISEASES OR CONDITIONS, if any, which gave rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR. 15 1/2 yrs	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) _____					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 4 1968 to June 14 1968, that (I) (we) last saw the deceased alive on June 14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John V. Conway, M.D.				23B. DATE SIGNED 9-9-68	
23C. PHYSICIAN'S NAME (Type) John V. Conway, M.D.				23D. ADDRESS 914D ST BALTO 19 MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/11/68		24C. NAME OF CEMETERY or CREMATORY OAK LAWN	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		24E. DATE REC'D BY HEALTH DEPT. SEP 12 1968		24F. NAME OF REGISTRAR Robert E. Farber	
24G. FUNERAL DIRECTOR J.G. CONNELLY SONS		24H. ADDRESS 300 MACE			

~~SECRET~~

President

Executive Order

1954

1954

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9290
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EUGENE GARY RHODES		2. DATE AND HOUR OF DEATH 9-10-68 4:45 A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Harford 6200		
		C. CITY OR TOWN BEAIR	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER RT. 4 BOX 315 (Prospect Mill Rd.)		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-50	9. AGE (In years last birthday) 18
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ERNA J. Rhodes ERNA J. RHODES		14. MOTHER'S MAIDEN NAME ANNA Elizabeth Caudill ELIZABETH CAUDILL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-50-1928	17. INFORMANT (Father) 838-3091 ADDRESS Mr. ERNA J. Rhodes BELAIR, Maryland 21014	
18. 1922 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest Minutes (B) Metastatic CA Months (C) Spinal Cord Tumor Months		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 1931 II				
19A. DATE OF OPERATION 7/31/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. HOW DID INJURY OCCUR?		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 9/10/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Frederick Crossman, Jr.		23B. DATE SIGNED 9/10/68		23C. PHYSICIAN'S NAME (Type) DEGREE
23D. ADDRESS DEGREE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Sept 12, 1968	24C. NAME OF CEMETERY or CREMATORY BELAIR Memorial Gardens	24D. LOCATION (City, town, or county) (State) BELAIR, Harford Co., Maryland 21014	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968	25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St BELAIR, Maryland 21014		

100-100000

X

(15 1000 100000)

100-100000

100-100000

100-100000

100-100000 100-100000
100-100000 100-100000
100-100000 100-100000

100-100000 100-100000
100-100000 100-100000
100-100000 100-100000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9291 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9291

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDWARD WILLIAM LINGELBACH		2. DATE AND HOUR OF DEATH 7 Sept. 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE 21222 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION D.O.A CITY HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN DUNDALK INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
				E. STREET AND NUMBER 7504 OLD BATTLE GROVE ROAD			
5. SEX MALE	6. RACE CAUSASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jun. 16, 1910	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lathe Operator			10B. KIND OF BUSINESS OR INDUSTRY Steel Mfrg.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Theodore			14. MOTHER'S MAIDEN NAME Virginia Phillips				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218/07/5261		17. INFORMANT Elsie R. Lingelbach-Wife		ADDRESS As in #4
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.9 I myocardial infarction				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH same day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II coronary occlusion				(B) DUE TO, OR AS A CONSEQUENCE OF:		same day	
				(C) arteriosclerotic heart disease		12 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 1 hypertension							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/1/15 19 55 to 9/7 19 68 , that (I) was last saw the deceased alive on 3/1 19 68 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was did not view the body after death.							
23A. SIGNATURE J. BLATT M.D.				23B. DATE SIGNED 9/9/68			
23C. PHYSICIAN'S NAME (Type) J. BLATT M.D.				23D. ADDRESS ESSEX RD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/10/68		24C. NAME of CEMETERY or CREMATORY Belair Mem. Grdns.		24D. LOCATION (City, town, or county) (State) Belair Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR W. Brooks Bradley		ADDRESS Dundalk, Md.	

I . . .

2022

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

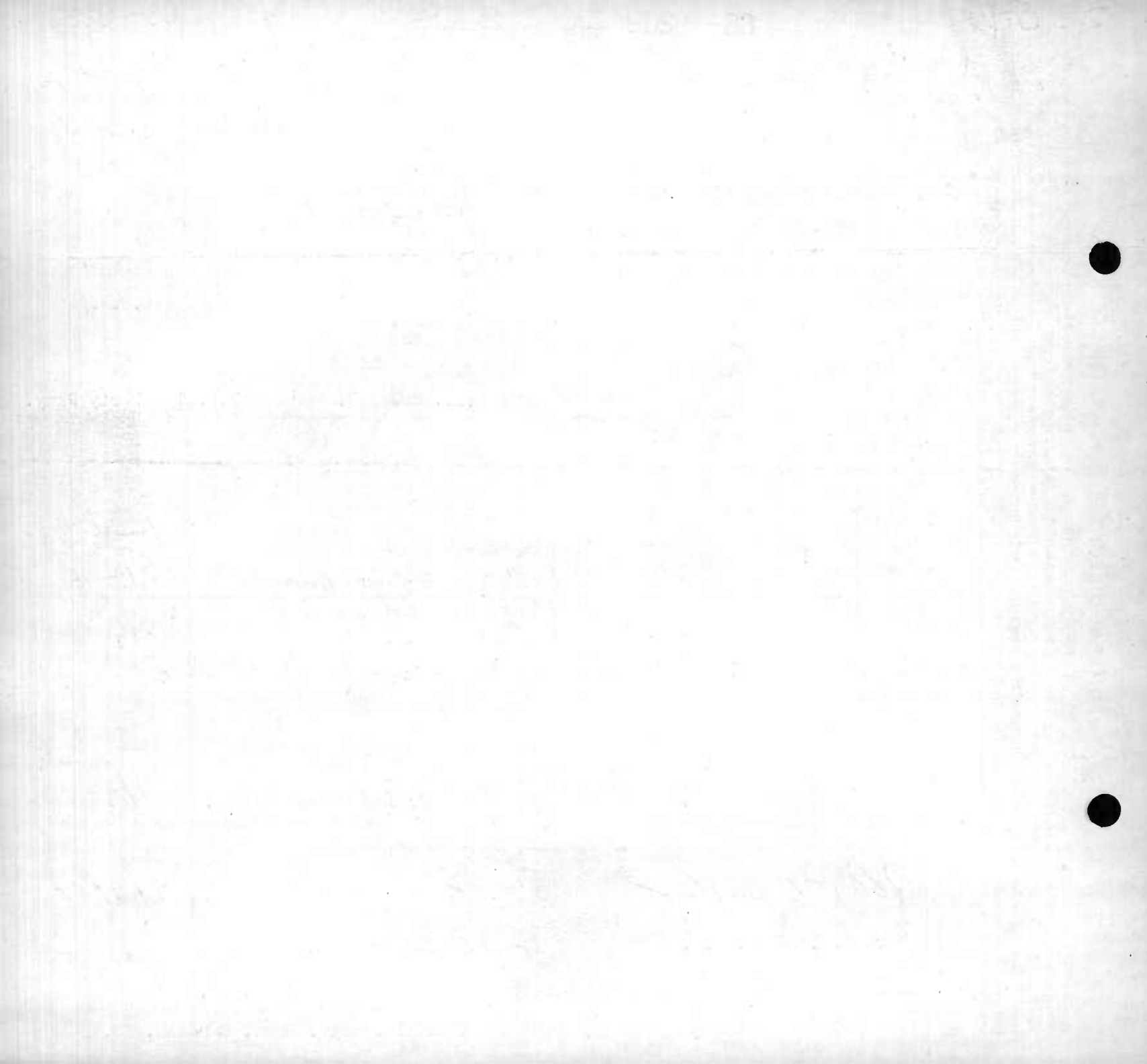
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9292 BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

REG. NO. 68- 9292

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Emma May Ruby		2. DATE AND HOUR OF DEATH 9/9/68 7:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in Pines-Belair Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6827 Dunbar Road		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 3, 1886	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-2722 F		17. INFORMANT Mrs. Mabel E. Westbrook, 2553 Liberty Pkwy.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Uremia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension Myocardial Infarction Symptomatic CA D. m. Osteoporosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 1 month > 1 month 1 yr 2 1/2 yr		
19A. DATE OF OPERATION 443X II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/30/1968 to 9/9/1968 , that (I) (we) last saw the deceased alive on 8/23/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 9/9/68	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.				23D. ADDRESS 4900 Belair Road.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Parkville, Md.		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9293 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

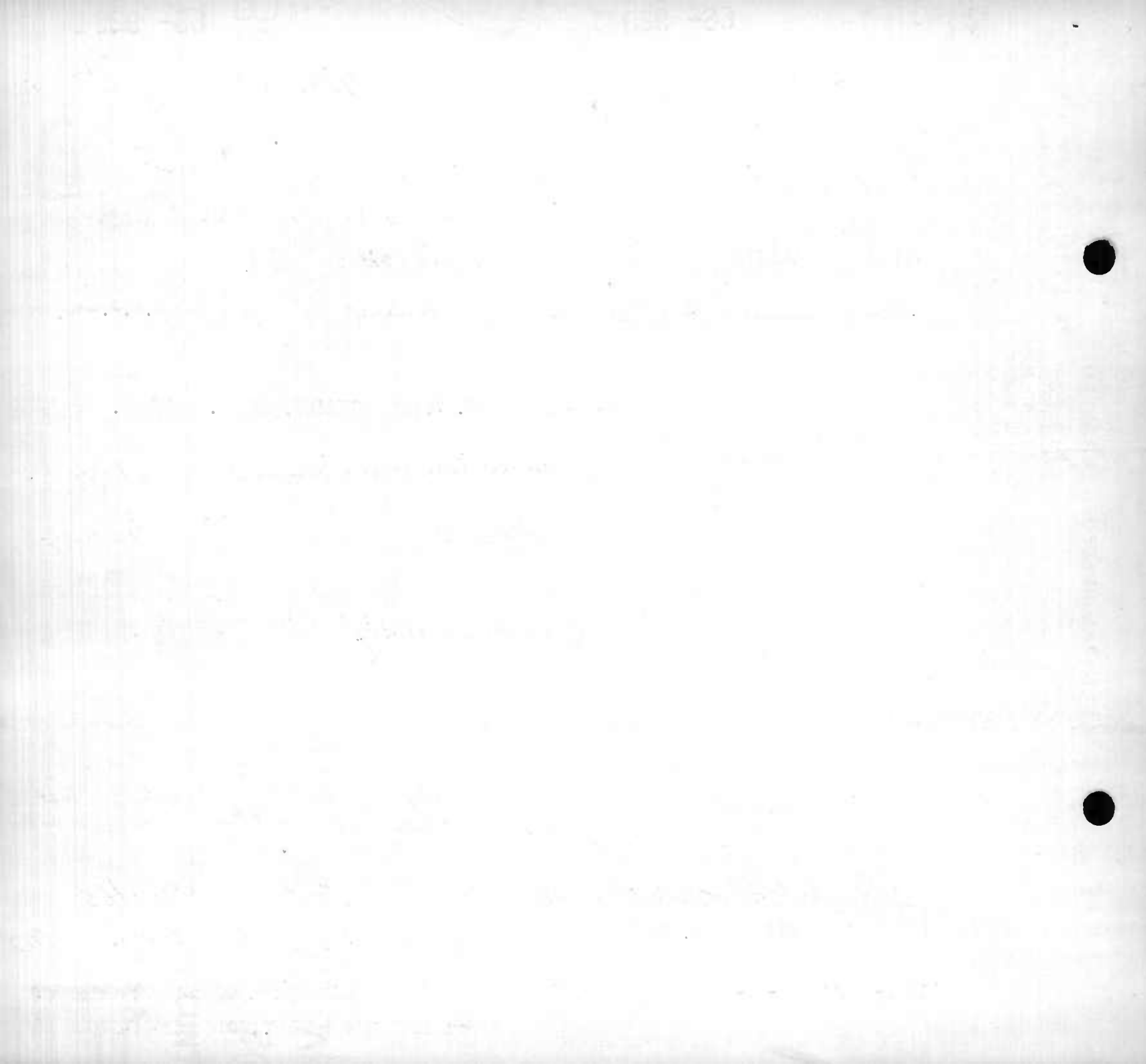
REG. NO. 68- 9293

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HARRY WALTER		2. DATE AND HOUR OF DEATH 9-7-68 12.15 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
		E. STREET AND NUMBER 110 N. LINWOOD AVENUE 81205			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-92	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John W.		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-0448		17. INFORMANT Fredericka Walter 110 N. Linwood Ave.	
18. 402X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cardiac failure 2nd to HBP		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. and Diabetic werner		(B) DUE TO, OR AS A CONSEQUENCE OF:		15 yr	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 444X II					
19A. DATE OF OPERATION 8	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8/13 19 68 to 9/7 19 68 , that (I) (we) last saw the deceased alive on 9/7 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas C. Butler		23B. DATE SIGNED 9/7/68		23C. PHYSICIAN'S NAME (Type) Thomas C. Butler	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/10/68		24C. NAME OF CEMETERY or CREMATORY Meadow Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Dabrowski Funeral Home	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

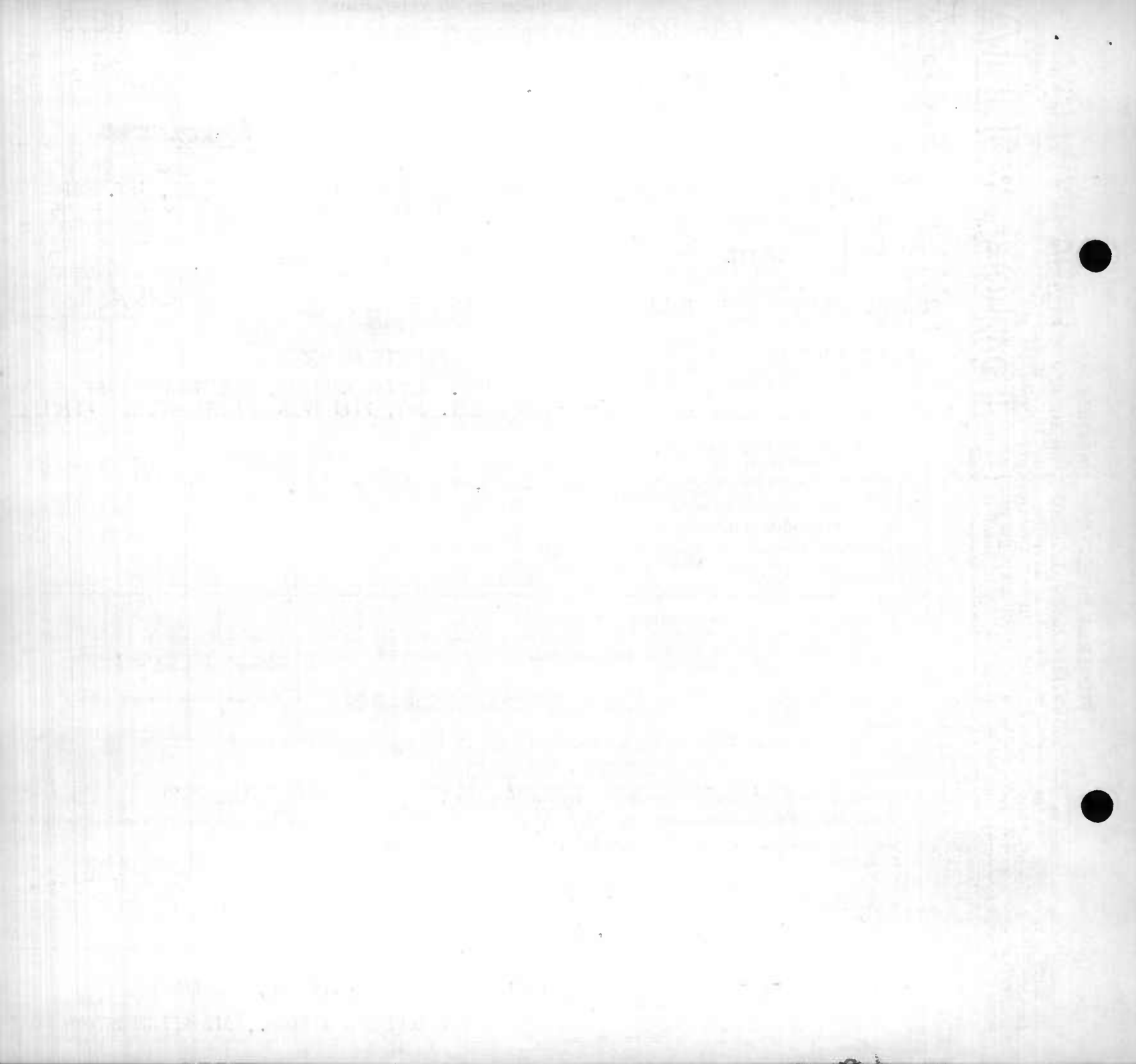
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9294					
1. NAME OF DECEASED (Type or Print) Philip Barish				2. DATE AND HOUR OF DEATH 9/9/68 8:15 <small>A.M.</small>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore 42				A. STATE MD B. COUNTY									
				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
				E. STREET AND NUMBER 4806 Palmer Ave									
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/15/1985		9. AGE (In years last birthday) 82		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEALER				10B. KIND OF BUSINESS OR INDUSTRY NEWS PAPERS				11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN BARISH				14. MOTHER'S MAIDEN NAME BATLA ?									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 261-40-3398		17. INFORMANT MRS. PETER GOTTLIEB, 235 E. 22nd ST. NEW YORK				ADDRESS			
18. 412.41-25019 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: ASCVD DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 20 years					
19A. DATE OF OPERATION 422.1 II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 9/9 1968 to 9/9 1968 , that (I) (<u>we</u>) last saw the deceased alive on 9/9 1968 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.													
23A. SIGNATURE Stanford H. Malinow MD								23B. DATE SIGNED 9/9/68					
23C. PHYSICIAN'S NAME (Type) STANFORD H. MALINOW								23D. ADDRESS Sinai Hospital Balt MD					
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL				24B. DATE 9-12-68		24C. NAME OF CEMETERY or CREMATORY WORKMEN CIRCLE (BETH EL)				24D. LOCATION (City, town, or county) (State) PARAMUS, NEW JERSEY			
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968				25B. NAME OF REGISTRAR Robert E. Johnson				25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

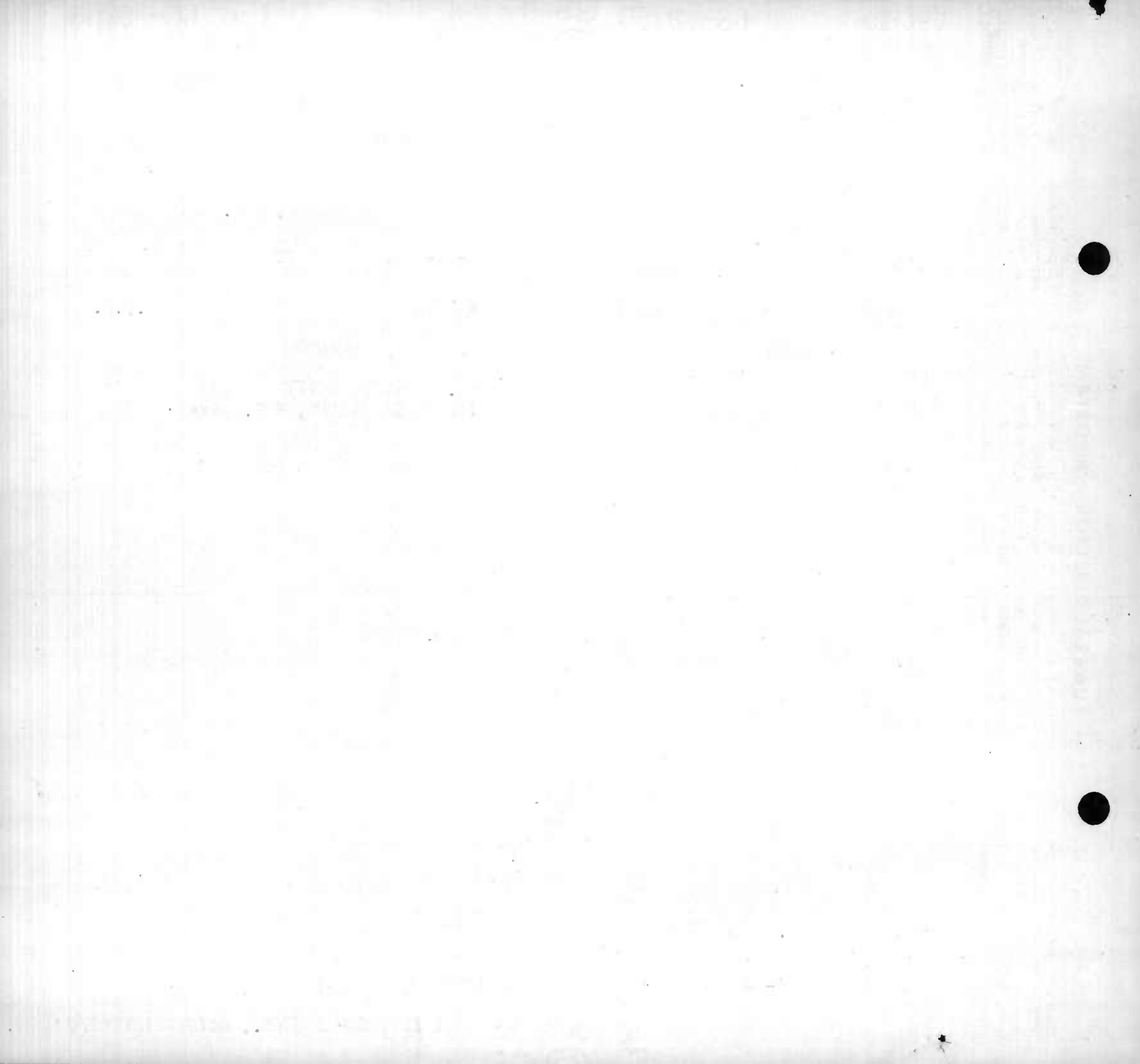
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9295
BIRTH NO. K-155				
1. NAME OF DECEASED KAUFMAN (Type or Print)		2. DATE AND HOUR OF DEATH 9/9/68 14³⁰ A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY [REDACTED]		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> No <input type="checkbox"/>		
		E. STREET AND NUMBER 7111 Park Heights Ave #15		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/02	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL MANAGER		10B. KIND OF BUSINESS OR INDUSTRY FULD BROTHERS		11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME JOSEPH KAUFMAN		14. MOTHER'S MAIDEN NAME FRANCIS KERNGOOD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-07-4895A		17. INFORMANT MRS. FLORINE KAUFMAN, PARK TOWERS EAST APT. 501, 7111 PARK HEIGHTS AVENUE #21215
18. 74X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cancer of Breast DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 months.		
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 30 1968 to Sept 9 1968 , that (I) (we) last saw the deceased alive on Sept 8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Daniel Greenwood, MD DEGREE		23B. DATE SIGNED Sept 9, 1968		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) DANIEL GREENWOOD, MD DEGREE		23D. ADDRESS SINAI HOSP		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-10-68	24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968	25B. NAME OF REGISTRAR Robert E. [REDACTED]	25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

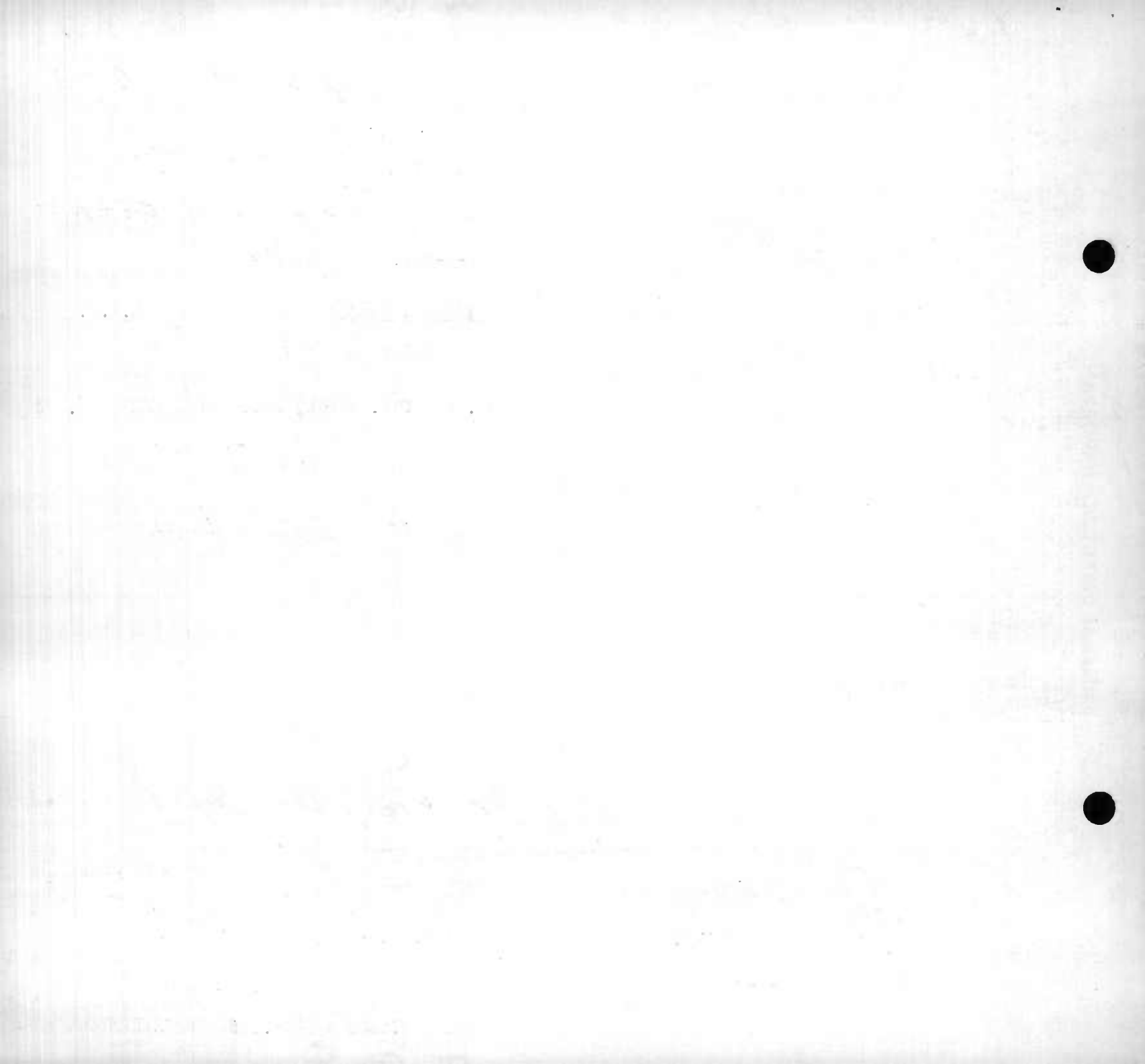
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9296	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Samuel G. Quitt</i>		2. DATE AND HOUR OF DEATH <i>Sept. 8, 1968 9:40 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI HOSPITAL</i> <i>42</i>			A. STATE <i>MARYLAND</i> B. COUNTY <i>53-00</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>130 SLADE AVENUE, APT. 309 #21208</i>					
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-29-1896</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETAIL</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>MEATS</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>	
13. FATHER'S NAME <i>UNKNOWN</i>			14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. BEATRICE QUITT</i> <i>130 SLADE AVENUE, APT. 309 #21208</i>	
18. <i>712.1 + 250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary artery disease</i> (B) <i>ASCUD</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Diabetes Mellitus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>9-9-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-8</i> 19 <i>68</i> to <i>9-8</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9-8</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>M. Horenstein</i>				23B. DATE SIGNED <i>9-9-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. HORENSTEIN</i>				23D. ADDRESS <i>Sinai Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-9-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>CHIZUK AMUNO (ARLINGTON)</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

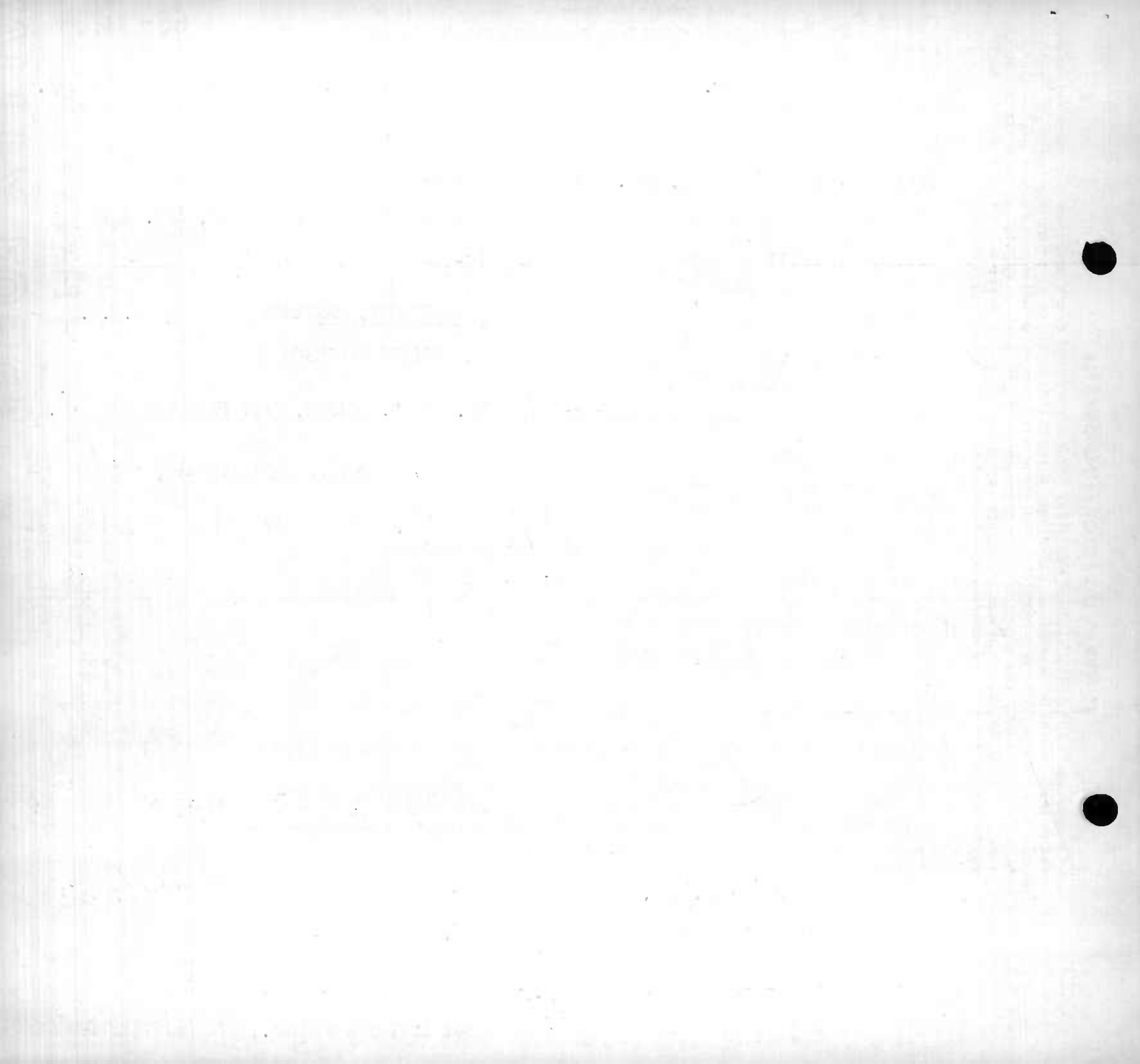
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9297
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Brown Samuel</u>		2. DATE AND HOUR OF DEATH <u>Sep 6 1968</u> <u>9.15 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>23-00</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3569 Philip Dr. of 286752</u>		
5. SEX <u>MALE</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1884</u>	9. AGE (In years lost birthday) <u>84</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURRIER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PROPRIETOR</u>		11. BIRTHPLACE (State or foreign country) <u>WARSAW, POLAND</u>
13. FATHER'S NAME <u>HERSCHEL BROWN</u>		14. MOTHER'S MAIDEN NAME <u>BLIMA ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. DAVID S. BROWN, 3625 ANTON FARMS RD. #8</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest</u> (B) <u>Poss. Intestinal Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>no op</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Sep 6 1968</u> to <u>Sep 6 1968</u>, that (I) (we) last saw the deceased alive on <u>Sep 6 19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>M. Nagayoshi</u>		23B. DATE SIGNED <u>9/6/68</u>		23C. PHYSICIAN'S NAME (Type) <u>M. NAGAYOSHI</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-8-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

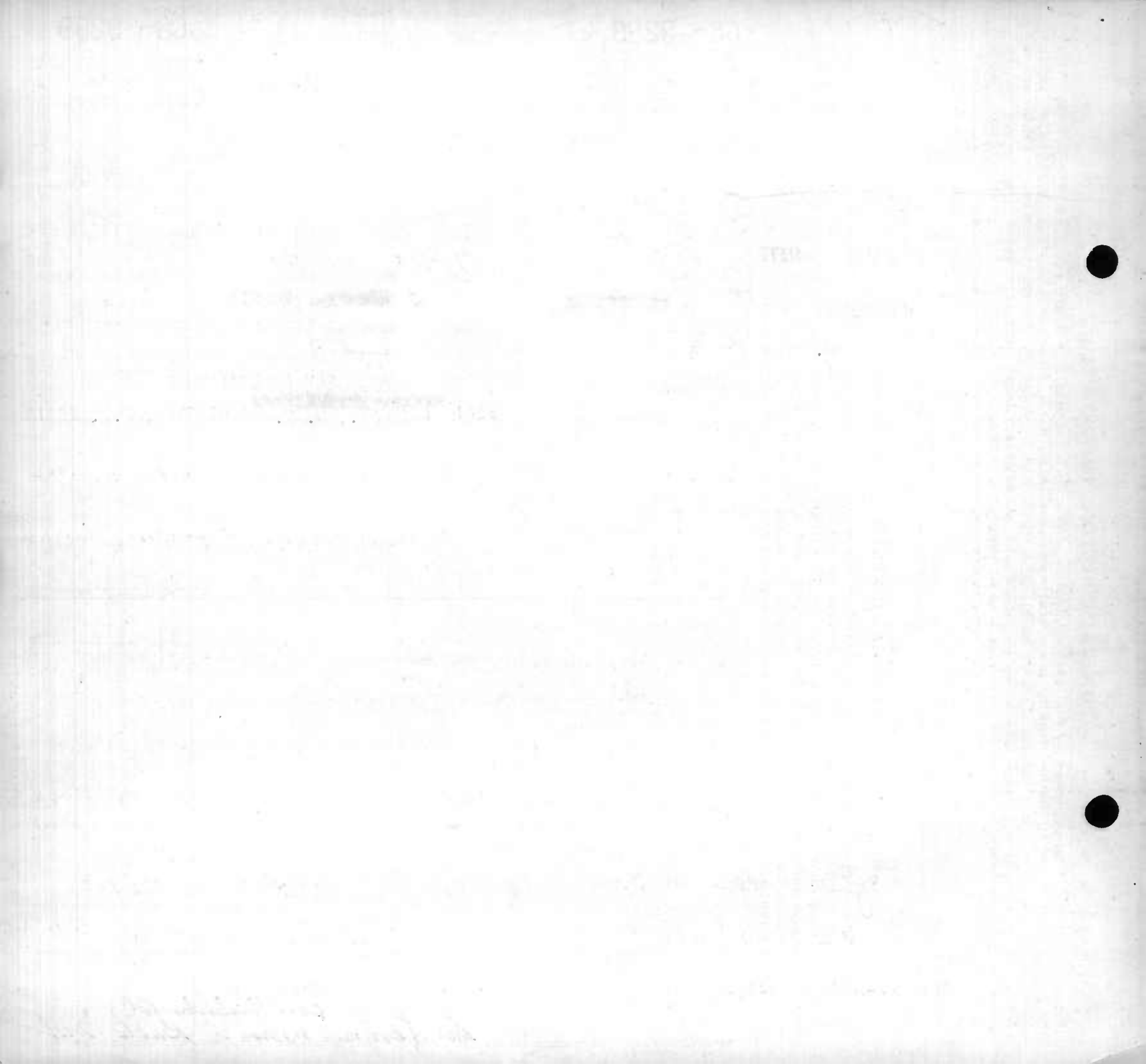
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9298
BIRTH NO. 1. NAME OF DECEASED (Type or Print) CHARLES M. BALDER		2. DATE AND HOUR OF DEATH SEPTEMBER 8, 1968 8 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6607 PARK HEIGHTS AVENUE, APT. A 1		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 6607 PARK HEIGHTS AVENUE, APT. A 1		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1890	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10B. KIND OF BUSINESS OR INDUSTRY LAW		
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ABRAHAM BALDER		14. MOTHER'S MAIDEN NAME MOLLIE ROBINSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-3533		17. INFORMANT MRS. SYD G. BALDER, 6607 Park Heights Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/20/68 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Embolism, cerebral 24 hours		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arterial fibrillation 6 months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 4-20-68 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Coronary sclerosis 10 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 0
22. I certify that (I) (this hospital) attended the deceased from Sept 7 May 19 53 to Sept 8 19 68 , that (I) (we) last saw the deceased alive on Sept 7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.				
23A. SIGNATURE Alan Bernstein		23B. DATE SIGNED 9/9/68		23C. PHYSICIAN'S NAME (Type) ALAN BERNSTEIN
23D. ADDRESS 819 PARK AVENUE		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 9-9-68		24C. NAME of CEMETERY or CREMATORY NEW HAR SINAI		24D. LOCATION (City, town, or county) (State) GARRISON, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

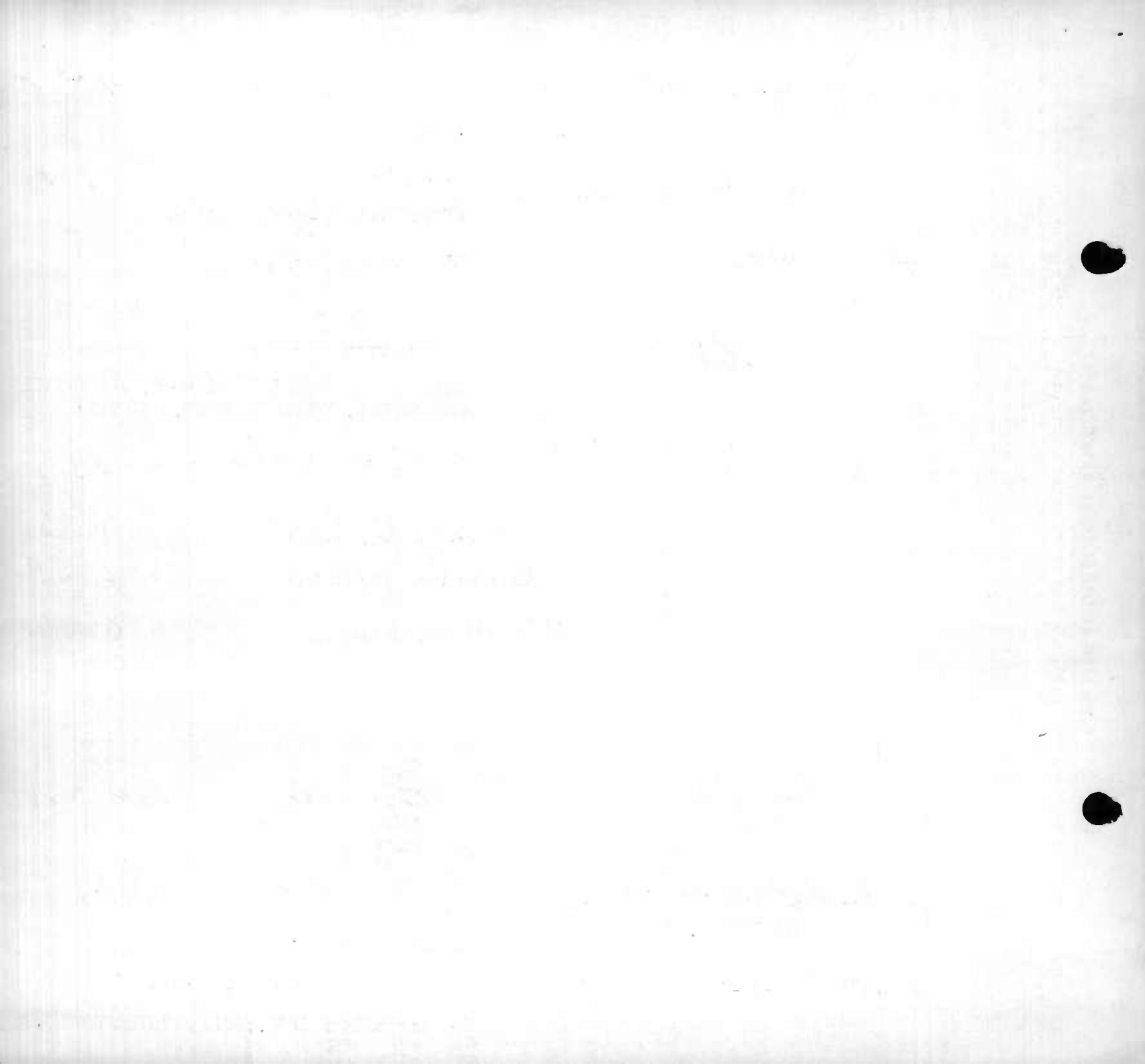
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9299
<div style="display: flex; justify-content: space-between;"> K-652 68- 9299 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		KRONSTADT, CLAIRE		9/10/68 8 ⁵³ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION USPHS Hosp. Wyman Park Dr. + 31 st St.			A. STATE D.C. B. COUNTY V-48		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Wash.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4528 Davenport St. NW		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/14	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Pauls			14. MOTHER'S MAIDEN NAME Anna ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?	17. INFORMANT DANZANSKY FUNERAL HOME ADDRESS 3501 14 th ST., N. W. WASHINGTON, D. D. 20010		
18. CAUSE OF DEATH 206.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Cardiorespiratory arrest minutes DUE TO, OR AS A CONSEQUENCE OF: (B) Acute monocytic leukemia months DUE TO, OR AS A CONSEQUENCE OF: (C)		
204.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/23 1968 to 9/10 1968, that (I) (we) last saw the deceased alive on 9/10/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JL Moake, M.D.			23B. DATE SIGNED 9/10/68		
23C. PHYSICIAN'S NAME (Type) Vic Duvall, M.D.			23D. ADDRESS USPHS Hosp. Wyman Park Dr. + 31 st St. Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL		24B. DATE 9-12-68		24C. NAME OF CEMETERY or CREMATORY ADAS ISRAEL	
24D. LOCATION WASHINGTON, D. C.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Sol Levinson + Bros. Balto. Ind.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9300	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Talley Juanita ROBERTS</u>		2. DATE AND HOUR OF DEATH <u>9/9/68</u> <u>4 50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI Hospital of Baltimore</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY _____ 5. CITY OR TOWN <u>Balto</u> 6. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER <u>3915 W. Rogers Ave</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/22</u>	9. AGE (In years lost birthday) <u>46</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>MILTON Roberts</u>			14. MOTHER'S MAIDEN NAME <u>MARYLOU ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>WHEELER & THOMPSON FUNERAL HOME, 705 PRINCES ANNE STREET, FREDERICKSBURG, VIRGINIA</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Overwhelming Sepsis & Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cellulitis @ hand</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u> <u>6 month</u>	
19A. DATE OF OPERATION <u>260X II</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9/9</u> 19<u>68</u> to <u>9/9</u> 19<u>68</u>, that (1) (we) last saw the deceased alive on <u>9/9</u> 19<u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanford H. Malinow MD</u>				23B. DATE SIGNED <u>9/9/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANFORD H. MALINOW</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL (REMOVAL)</u>		24B. DATE <u>9-13-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>CONFEDERATE</u>	
24D. LOCATION (City, town, or county) (State) <u>SPOTSYLVANIA, COUNTY, VIRGINIA</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jarboe</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-355		68- 9301		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9301	
1. NAME OF DECEASED (Type or Print) Laura RETTMAN				2. DATE AND HOUR OF DEATH 9-10-68 12:45 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Levindale Hebrew Home & Infirmary				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER LEVINDALE AGED HOME							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-29-92	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) ROMANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM DOLINGER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS MR. ABE ABRAMOWITZ, 6641 SANZO ROAD #21209			
18. 2374 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (B) Tumor Renal Pelvis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 8 months	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 236X II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-18-1958 to 9-10-1968 , that (I) (we) last saw the deceased alive on 9-10-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ardaiz				23B. DATE SIGNED 9-10-68			
23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ				23D. ADDRESS 7 Oberlin Crt. Towson, Md. 21204			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-11-68		24C. NAME of CEMETERY or CREMATORY SHAAREI ZION		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed at final disposition is made.

68- 9302 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9302

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Butler, Fulton		2. DATE AND HOUR OF DEATH September 9th, 1968 5:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 63-00			
FULL NAME OF HOSPITAL OR INSTITUTION 40 Saint Agnes Hospital Caton & Wilkins Aves. 21229		C. CITY OR TOWN Elkridge		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 5417 Race Rd. 21227			
5. SEX m	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/04	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Henry Butler		14. MOTHER'S MAIDEN NAME Martha Gaither	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Carrie V. Butler 5417 Race Road 21227	
18. 4/2/3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante coronary heart disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart disease			
		(B) Cardio Vascular disease DUE TO, OR AS A CONSEQUENCE OF:		2 yrs	
		(C) Chn Arthritis		5 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from July 19 66 to Sept 9 1968 , that (1) (we) last saw the deceased alive on Sept 9 1968 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce Brumbaugh MD		23B. DATE SIGNED 9/11/68		23C. PHYSICIAN'S NAME (Type) 5 B Bruce Brumbaugh MD	
23D. ADDRESS 5309 main st Elkridge Md 21227		23E. NAME OF REGISTRAR Charles A. Rice		23F. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/68		24C. NAME OF CEMETERY or CREMATORY Saint Rest	
24D. LOCATION Harmon Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 12 1968		24F. NAME OF REGISTRAR Charles A. Rice	

THE
 UNITED STATES
 DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

OFFICE OF THE SECRETARY

T 453

68- 9303

BALTIMORE CITY HEALTH DEPARTMENT

68- 9303

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RALPH TOLAND		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 2, 1968 Hour 7:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital 9-27-68		3. DATE PRONOUNCED DEAD Month Day Year Hour September 2, 1968 7:45 P.M.	
6. SEX male 7. RACE negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-08	
9. DATE OF BIRTH Apr. 16, 1948 10. AGE (In years last birthday) 20 11. BIRTHPLACE (State or foreign country) Newberry, S. Carolina		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 1013 Mt. Holly St.	
13. FATHER'S NAME Earl Toland		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Car	
15. MOTHER'S MAIDEN NAME Bladys White		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 24-50-4297		18. INFORMANT Earl Toland ADDRESS 1013 Mt. Holly St	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cranio-Cerebral Injury ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9-7-68 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Edmondson Avenue E. of Hilton St.		22D. TIME OF INJURY (APPROX.) 8:27-68 - 3:55 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? (Passenger) in car - involved in a broadside collision with another car.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/3/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Westport (Baltimore) Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Spitz, M.D.	
25C. FUNERAL DIRECTOR Joseph L. Russ		ADDRESS 2522 W. Montrose, Baltimore, Md.	

James E. G.

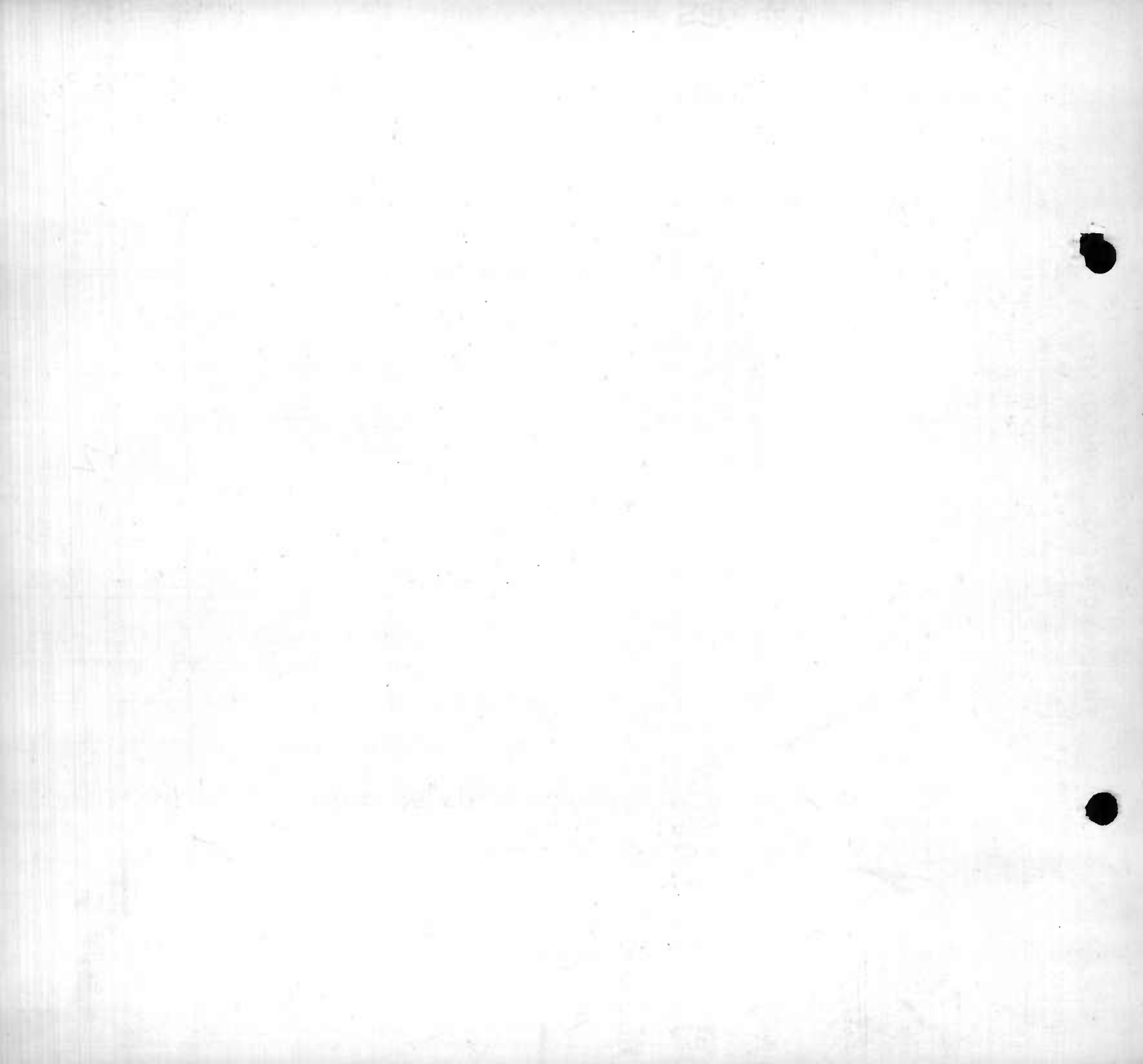
VALLEY 2-10-68

2-10-68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9304	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHNSON, JAMES		9/5/68 3:46 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 12 SINAI HOSPITAL			A. STATE Maryland B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3446 Park Heights Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
Male	Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 14, 1899	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Columbia S. Carolina	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Johnson			Hannah McClaine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs. Christine Waters 5502 Wesley Ave.	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		SPONTANEOUS PNEUMOTHORAX		12 hours	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		RES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		10 YEARS.	
		CHRONIC OBSTRUCTIVE LUNG DIS - BULLA FORMATION			
		(C) ASCUD		10 YEARS.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
5-27-1 II				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 9/5/68 10:00 AM to 9/5/68 3:46 PM, that (X) (we) last saw the deceased alive on 9/5/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
ERIC JUDITZ				9/5/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ERIC JUDITZ				SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-9-68		Mt. Auburn Cemetery Westport (Baltimore) Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 12 1968		R. E. E. E. E.		Joseph H. Russ 2222 N. Harbor	



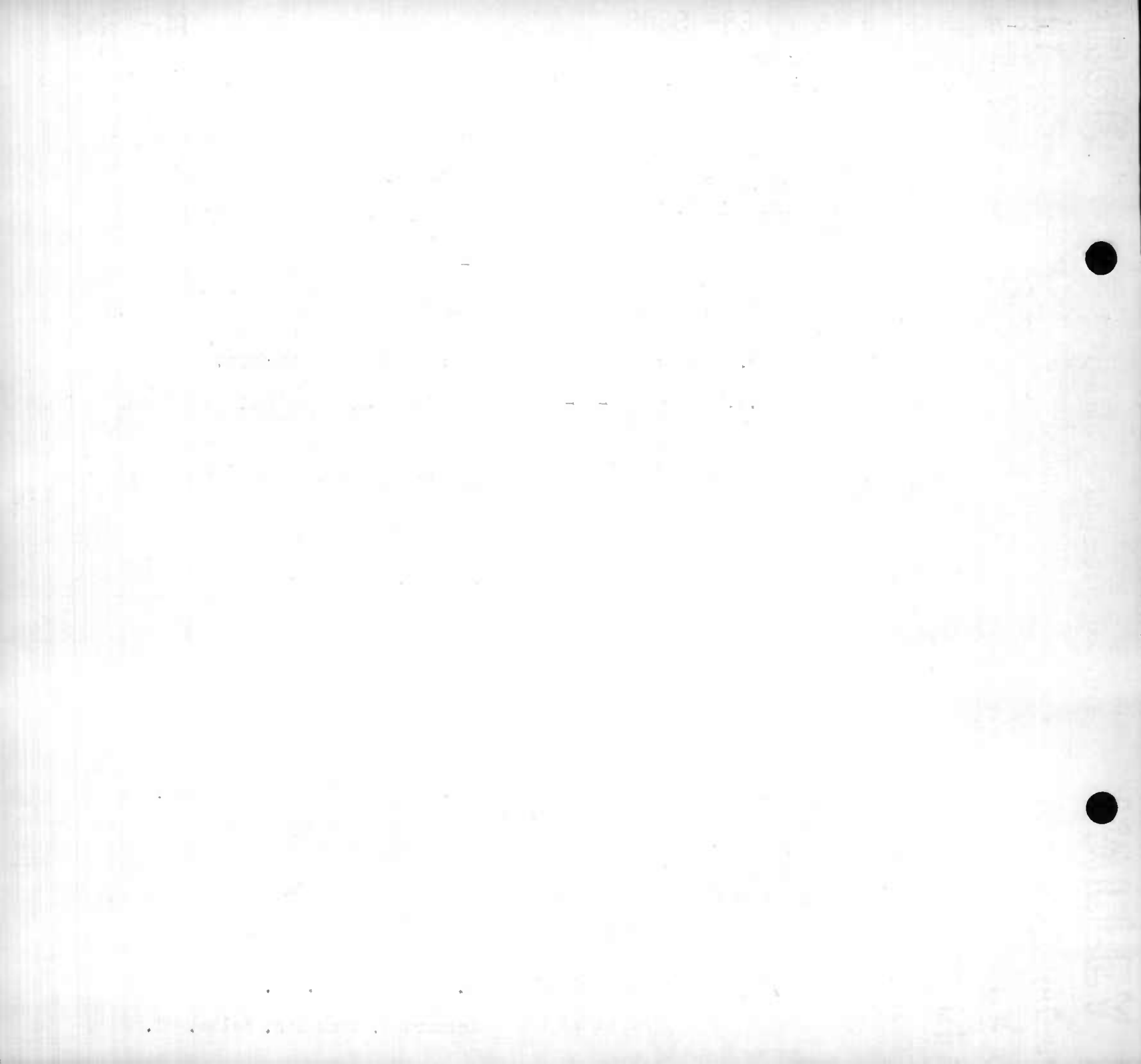
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9305	
68- 9305				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Cramblitt Milton J.		9.11.68 7:24 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
				A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
36 Franklin Square Hospital				MARYLAND 20-05 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
433 S. MURROW ST.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9.20.29	38	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Salemman		Baking		Baltimore	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert Cramblitt			ANNA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES Yes 47-50		9063 214-24-0000		BERNADETTE CRAMBLITT 433 S. MURROW ST	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
420.1 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from (2:45 PM) 9.11.1968 to (7:24 PM) 9.11.1968, that (I) (we) last saw the deceased alive on 9.11.68 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. J. B. R.				9.11.68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR. AFZAL MD				FRANKLIN SQUARE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-16-68		BALTO. NATIONAL	
				BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 12 1968		Robert E. [Signature]		GEO. L. SCHWAB, FUNERAL HOME 11 Francis M. Miller 21011 Redwood Ave	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

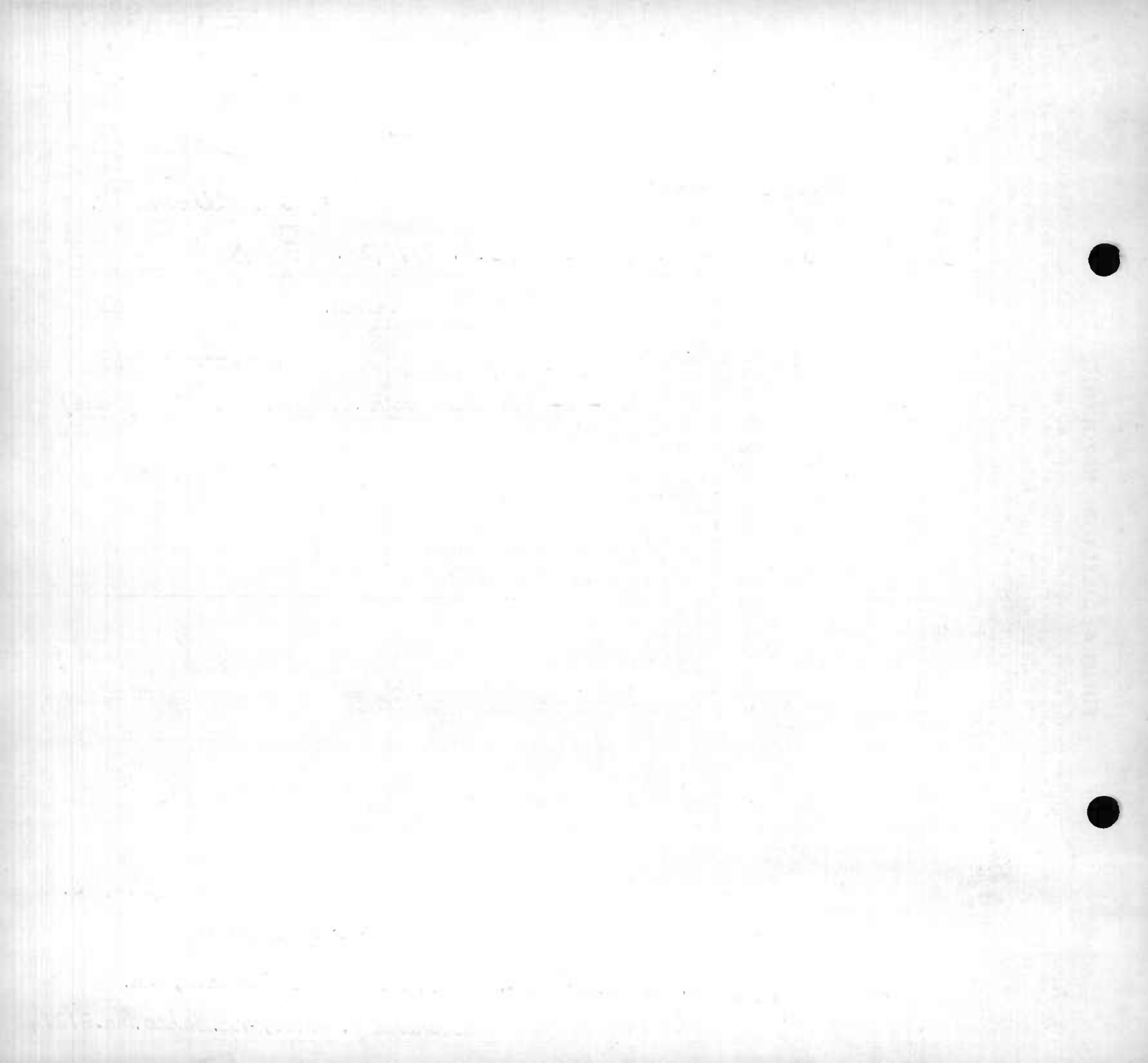
BIRTH NO.		1. NAME OF DECEASED <u>Hanna</u>		2. DATE AND HOUR OF DEATH <u>9/11/68</u> <u>2 00</u> <u>14</u> M.	
(Type or Print) <u>Robert Webster</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2106 Erdman Avenue,</u>		F. ZIP CODE <u>#21218</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1-15-20</u>	9. AGE (In years lost birthday) <u>48</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Smith & Voale</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Namon H. Webster</u>		14. MOTHER'S MAIDEN NAME <u>Anna White</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.2</u>		16. SOCIAL SECURITY NO. <u>216-14-0202</u>		17. INFORMANT <u>RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 10</u> <u>immed</u> <u>8 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>420.1 II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (i) (this hospital) attended the deceased from <u>9/9/68</u> 19 to <u>9/11/68</u> 19, that (ii) (we) last saw the deceased alive on <u>9/11/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David Ceehn M.D.</u>				23B. DATE SIGNED <u>9/11/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>DAVID ACKER M.D.</u>		23D. ADDRESS <u>4940 Eastern Ave Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/13/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens Of Faith Cem.</u>	
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Seaburn</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9307	
<div style="display: flex; justify-content: space-between;"> 68-9307 CERTIFICATE OF DEATH BIRTH NO. </div>					
1. NAME OF DECEASED (Type or Print) <i>Elizabeth T. Kramer</i>			2. DATE AND HOUR OF DEATH <i>9-11-68</i> <i>6²⁰ A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY		
5. SEX <i>Female</i>			6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>Feb. 23, 1923.</i>
13. FATHER'S NAME <i>George Kramer</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Hoff</i>		9. AGE (In years last birthday) <i>45</i> If Under 1 Yr. Months Days If Under 24 Hrs. Min.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>187-18-2202</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			17. INFORMANT <i>Miss Ruth Reimschuessel</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Intestinal obstruction about 1 month</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>5-20-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/16/68</i> to <i>9/11/68</i> , that (I) (we) last saw the deceased alive on <i>9/11/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. J. J. J.</i>				23B. DATE SIGNED <i>9/11/68.</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. J. J. J.</i>				23D. ADDRESS <i>Mercy Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/14/68.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Mem. Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1968</i>			
25B. NAME OF REGISTRAR <i>Leonard J. Ruck, Inc.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>			

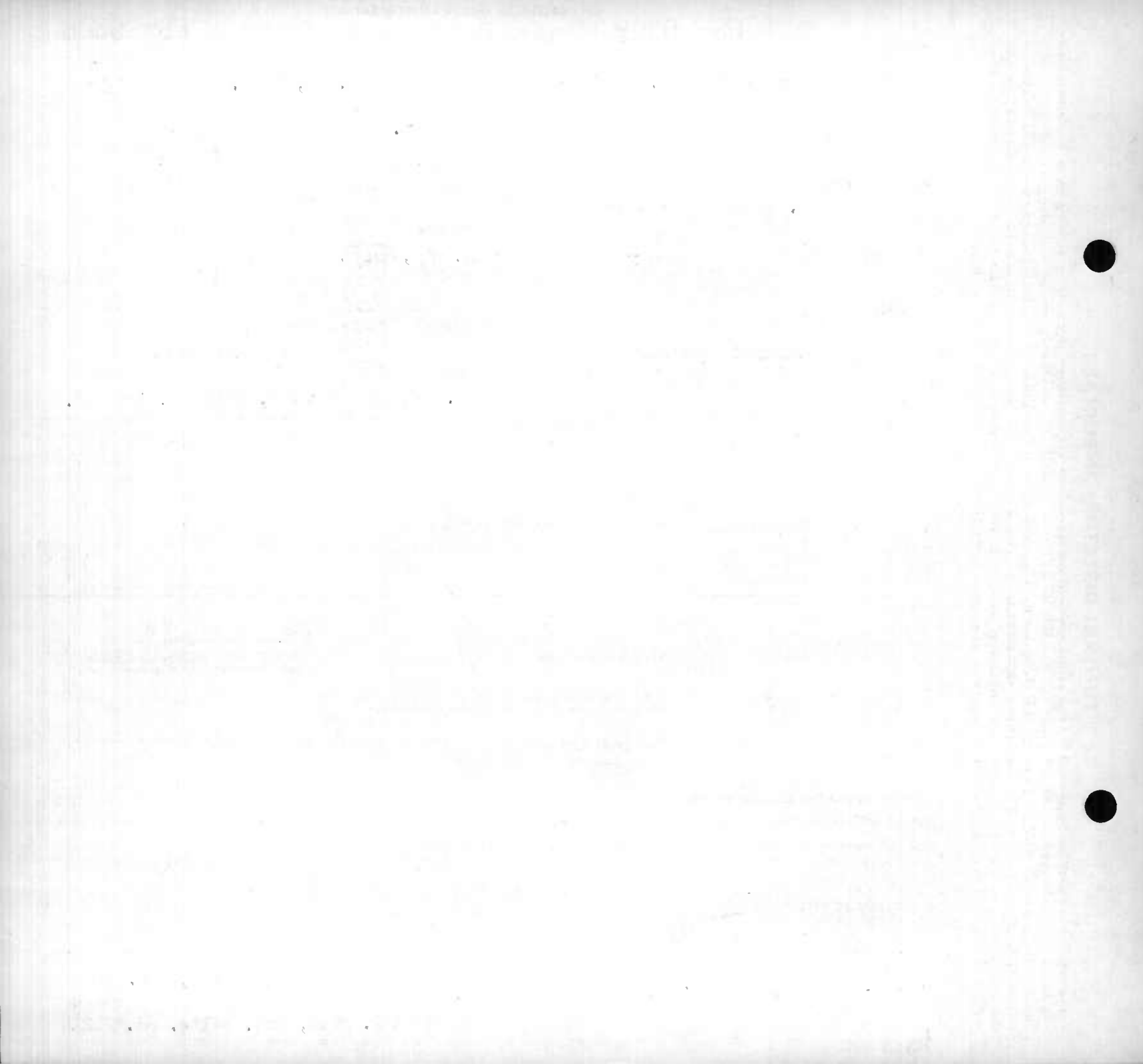


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9308 CERTIFICATE OF DEATH

REG. NO. 68- 9308

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PAULINE E. GROTHAUS		Sept. 11, 1968. 1:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines 2525 W. Belvedere Avenue				A. STATE Md. B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3610 Ednor Road	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 17, 1887.	9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME August Munzner				14. MOTHER'S MAIDEN NAME Augusta Koch	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Wallace Grothaus, 1636 Aberdeen Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 II DISEASE OR CONDITION CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		CAUSE OF DEATH Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHD (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1968 to Sept. 11, 1968, that (I) (we) lost saw the deceased alive on Sept. 9, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Toms, M.D.				23B. DATE SIGNED 9/11/68	
23C. PHYSICIAN'S NAME (Type) Stephen Toms, M.D.				23D. ADDRESS 1712 WINFORD RD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/68		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Carls		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



52-57-21

CEK

68- 9309

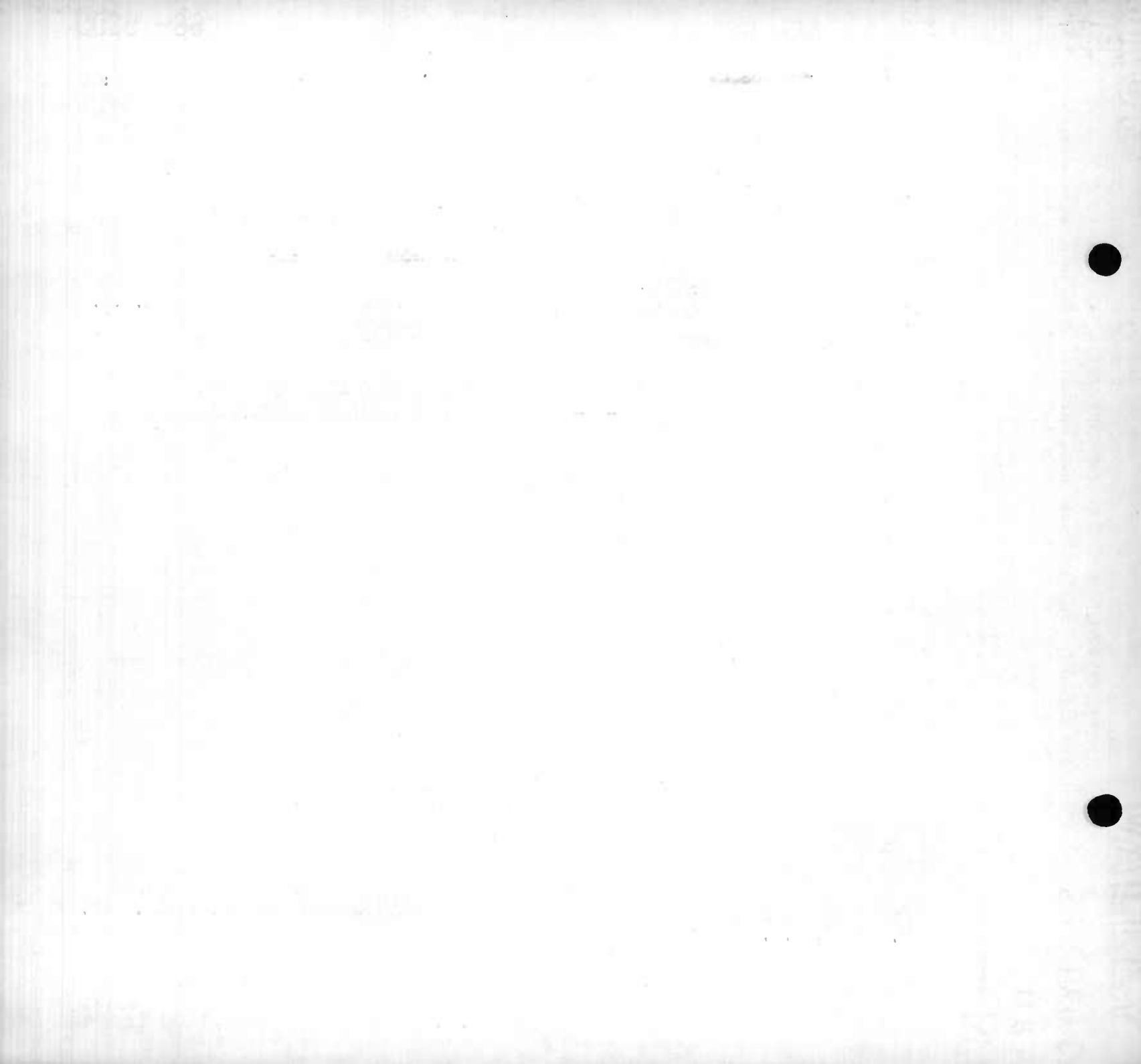
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9309

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN FRANK BARTEK		2. DATE AND HOUR OF DEATH 9/9/68 9:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2-03			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Humble Oil & Refining Co.		8. DATE OF BIRTH 10-23-12 03	
13. FATHER'S NAME JOSEPH BARTEK		14. MOTHER'S MAIDEN NAME JOSEPHINA SCZEPAN		9. AGE (In years last birthday) 55 64	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 188-09-8967		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
17. INFORMANT RECORDS: 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
18. 191X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. METASTATIC BRAIN TUMOR		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION 193.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 1 9/16		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR			
20A. AUTOPSY? (Yes or No) NO NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9/4/1968 to 9/9/1968 , that (I) (we) last saw the deceased alive on 9/9/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. BACCI, M.D.		23B. DATE SIGNED 9/9/68		23C. PHYSICIAN'S NAME (Type) F. BACCI, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/68		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR M.F. Sadowski & Sons, 1808 Eastern Ave	

FUNERAL DIRECTOR: IMPORTANT

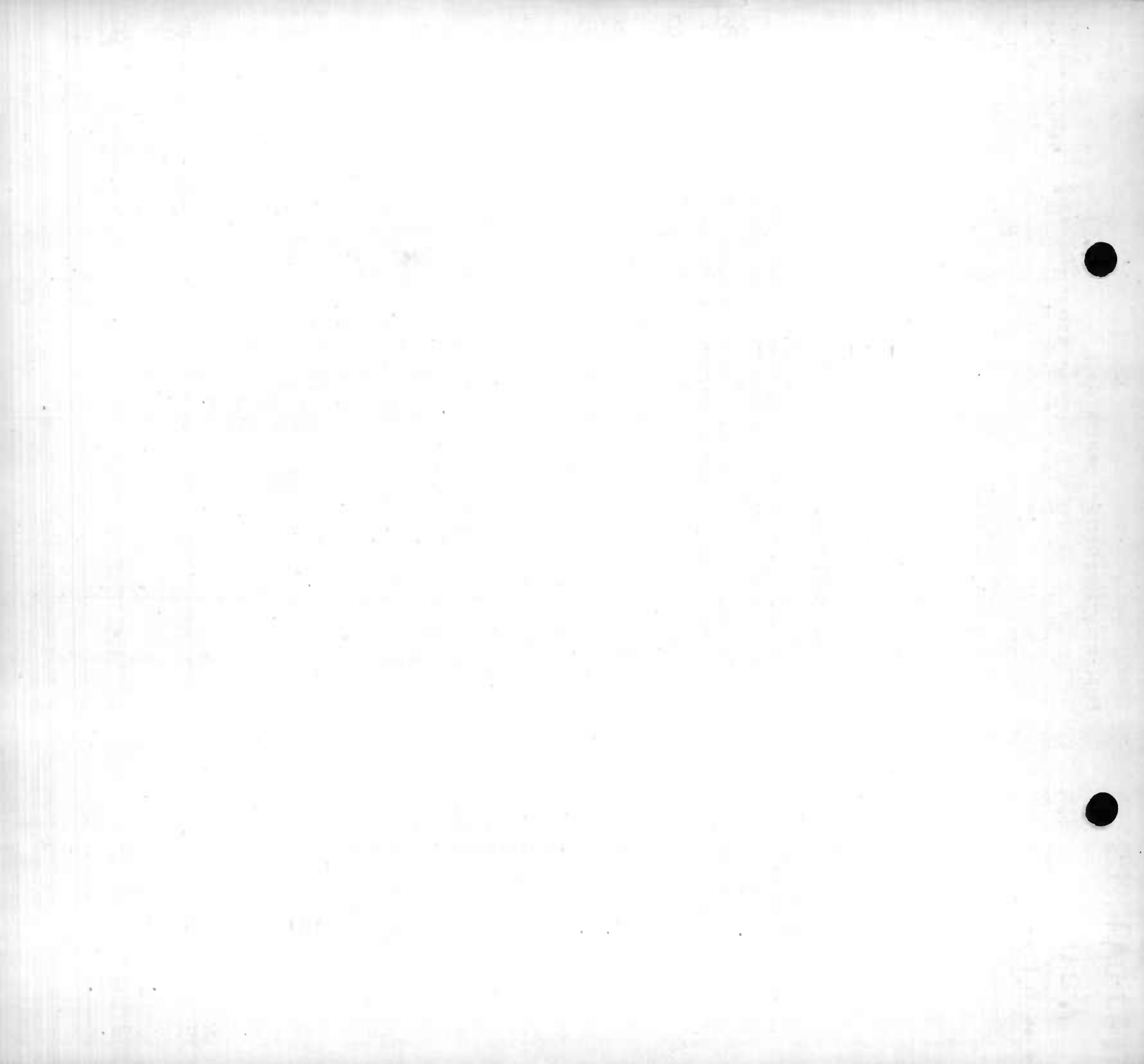
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

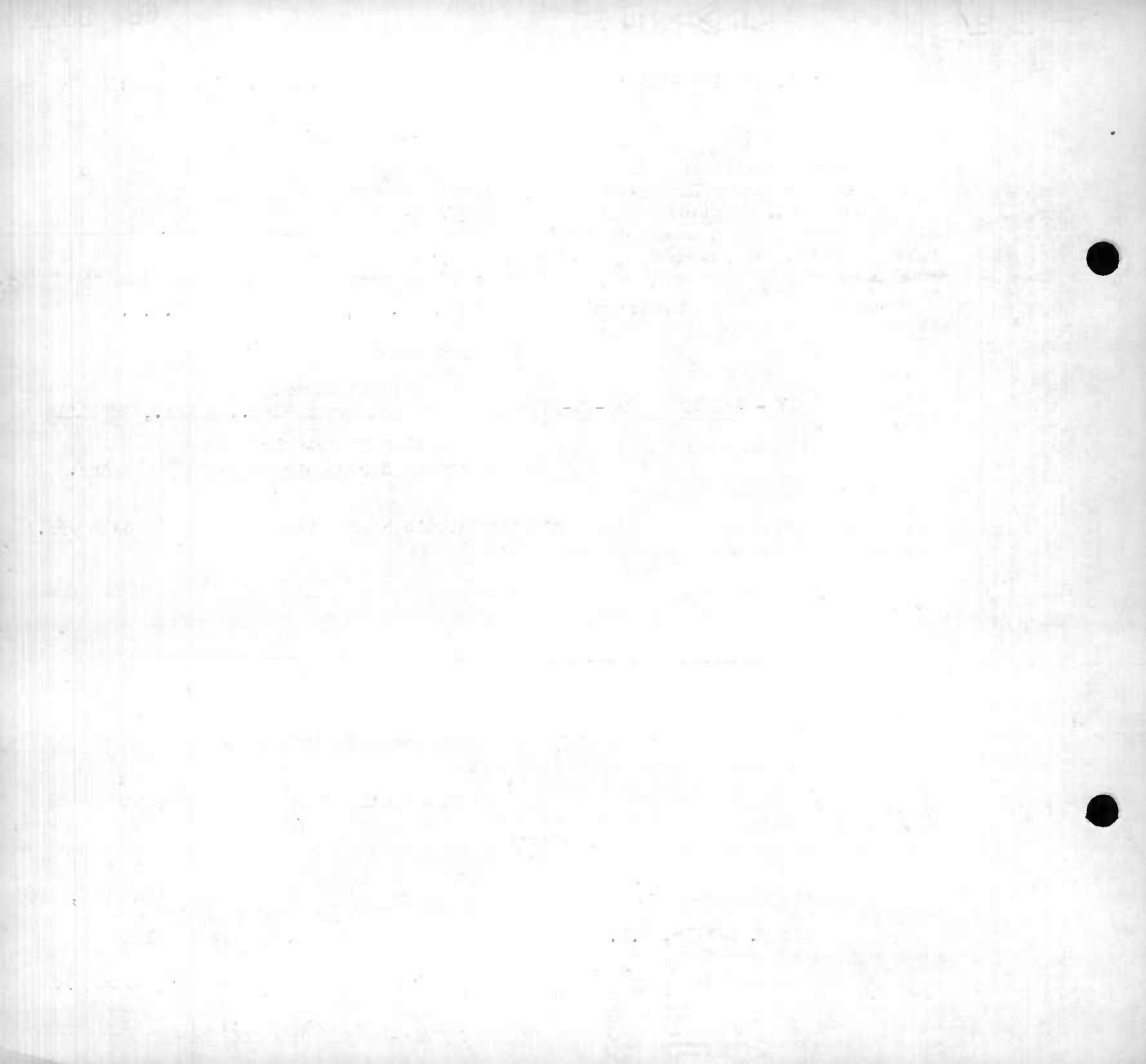
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9310	
1. NAME OF DECEASED (Type or Print) MARY Richardson			2. DATE AND HOUR OF DEATH 9/11/68 5 25 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1740 Normal Ave		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/24	9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME WILLIAM ROBINSON		14. MOTHER'S MAIDEN NAME HATTIE RICHARDSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Raymond Stern 1740 Normal Ave.	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE TERMINAL Uremia DUE TO, OR AS A CONSEQUENCE OF: (B) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF: (C) EMBOLOGICAL CARCINOMA		
19. 171X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/9 19 68 to 9/11 19 68 , that (I) (we) last saw the deceased alive on 9/11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John H. Stobo				23B. DATE SIGNED 9/11/68	
23C. PHYSICIAN'S NAME (Type) JOHN H. STOBO, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/68		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) STOUGH, William Wilbur		2. DATE AND HOUR OF DEATH September 5, 1968 6:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 914 Overbrook Road					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/97	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) York, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Henry Stough		14. MOTHER'S MAIDEN NAME Marg Knaub			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/14/17 - 2/4/19		16. SOCIAL SECURITY NO. 216-05-9728		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. 412.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Superior mesenteric artery thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic heart disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 14 hrs. (B) 20-30 yrs. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 426.0 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 4th 19 68 to September 5th 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 5th 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) view the body after death.					
23A. SIGNATURE Gary M. Lattin, M.D.		23B. DATE SIGNED September 5, 1968		23C. PHYSICIAN'S NAME (Type) GARY M. LATTIN, M.D.	
23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/7/68		24C. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	
24D. LOCATION York		24E. STATE Pennsylvania			
25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		25B. NAME OF REGISTRAR Robert E. Tolson		25C. FUNERAL DIRECTOR John Burns Sons	
25D. ADDRESS Tolson					

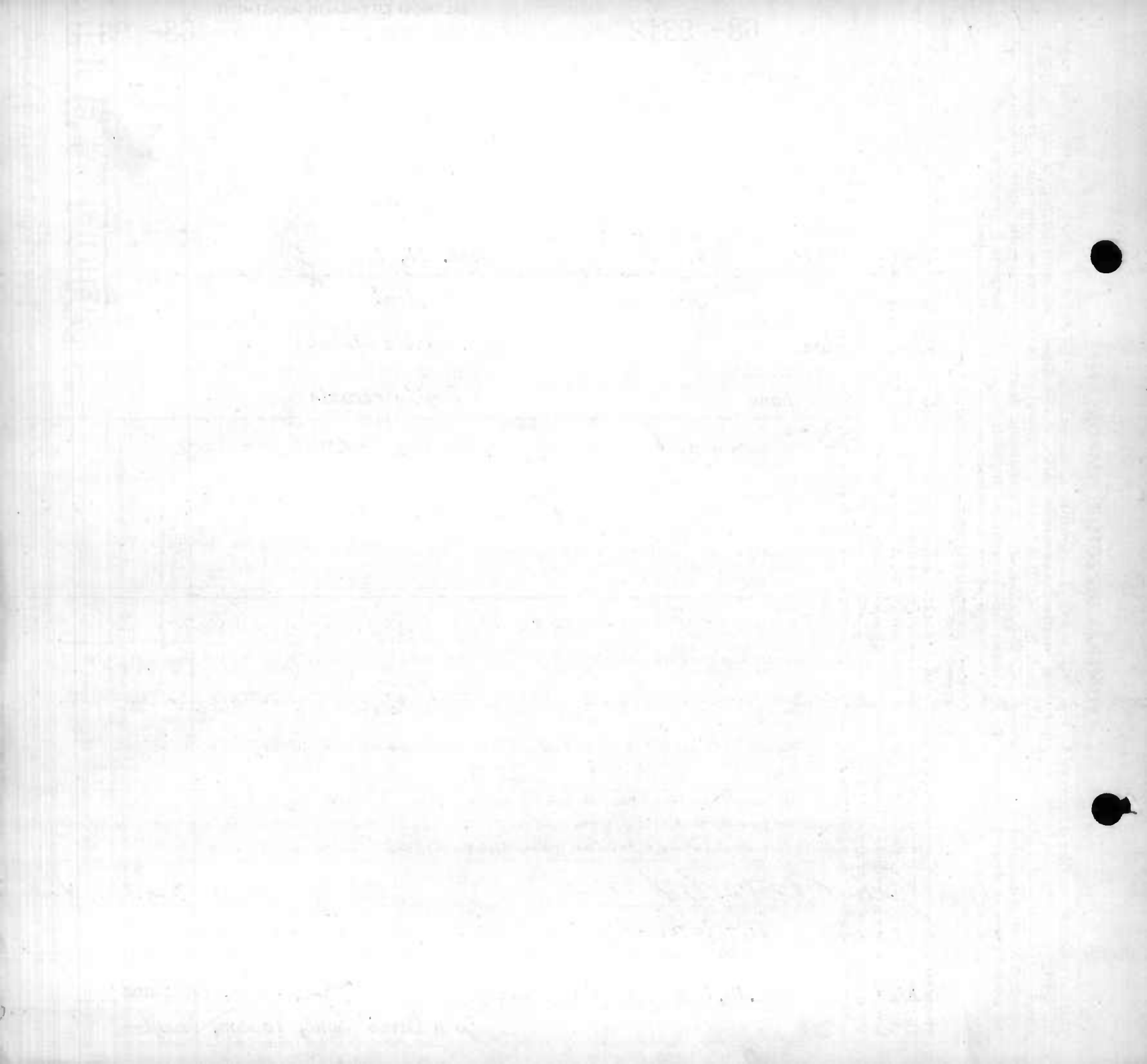


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9312 BALTIMORE CITY HEALTH DEPARTMENT X REG. NO. 68- 9312

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RUTH ELIZABETH GILLESPIE		2. DATE AND HOUR OF DEATH Sept. 7, 1968 4:00 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION U. S. PUBLIC HEALTH SERVICE 2X HOSPITAL		C. CITY OR TOWN COCKEYSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER Box 133					
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1930	9. AGE (In years lost birthday) 37	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert Naylor		14. MOTHER'S MAIDEN NAME Myrtle Wilhelm	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records	
ADDRESS					
18. 398X-1-2051 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RHEUMATIC HEART DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 416X II		CHRONIC MYELOCYTIC LEUKEMIA		2 YEARS	
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Sutherland, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept. 7, 1968	
23C. PHYSICIAN'S NAME (Type) JOHN C. SUTHERLAND		23D. ADDRESS 3100 WYMAN PARK DR.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Sept. 10, 1968	24C. NAME OF CEMETERY or CREMATORY Jessop's Cemetery		24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP. 12 1968		25B. NAME OF REGISTRAR John E. Jackson		25C. FUNERAL DIRECTOR ADDRESS John Burns' Sons, Towson, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9313

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPH CRIST, SR.		Sept. 9, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 4822 Bowland Avenue			A. STATE Md 21206		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4822 Bowland Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
male	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11/28/89	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Brewer American Brewery			Italy		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
unknown			Maria Catino		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
		216-01-4397	Mrs. Mary Storke, dght. above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 153.8 I CARCINOMA OF COLON (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: 153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 10/14 19 68 to 9/9 19 68, that (I) (we) last saw the deceased alive on 9/4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Dr. Irvin B. Kaplan MD			23B. DATE SIGNED 9/10/68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. Irvin B. Kaplan			129 S. Broadway		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial		9/11/68	Gardens of Faith Cem.		Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
SEP. 12 1968		Robert E. Taylor	Schimunek Funeral Home, Inc. 3331 Brehms Lane		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9314

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES W. MAC CUBBIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 7, 1968		Hour 6:55 P.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3618 Bonview Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year September 7, 1968		Hour 6:55 P.
6. SEX Male		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1/16/21		10. AGE (In years last birthday) 47	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard R. Mac Cubbin		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bureau of Sanitation		15. MOTHER'S MAIDEN NAME Neva L. Fink		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 2 - Army		17. SOCIAL SECURITY NO. 216-09-9506		
18. INFORMANT Lola L. Noonan, sister, above		ADDRESS		
19. CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus and Hodgkins Disease		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION 9/11/68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 8, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/11/68	24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968		
25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Schimmek Funeral Home, Inc.		
25D. ADDRESS 3331 Brehms Lane				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **68- 9315**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Bagdady, Louis		2. DATE AND HOUR OF DEATH 9/9/68 5:45 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Lincoln Memorial Nursing Home 27 N. Carey St. Baltimore, Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1415 W. Hollins St.	
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/28	9. AGE (In years last birthday) 40	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) unknown	
12. CITIZEN OF WHAT COUNTRY? Unknown		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 218-10-3383		17. INFORMANT Lincoln Memorial Nursing Home 27 N. Carey Street, Baltimore Md.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchogenic Carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/30 19 68 to 9/9 19 68 , that (I) (we) last saw the deceased alive on 9/9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hollis Seunarine M.D. DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) HOLLIS SEUNARINE DEGREE		23D. ADDRESS 1801 GREENBERRY RD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-68		24C. NAME OF CEMETERY or CREMATORY Green Orthodox Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 12 1968			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Nicholas T. Matthews 3021 Eastern Ave, Baltimore			

1901 2000 2000 2000

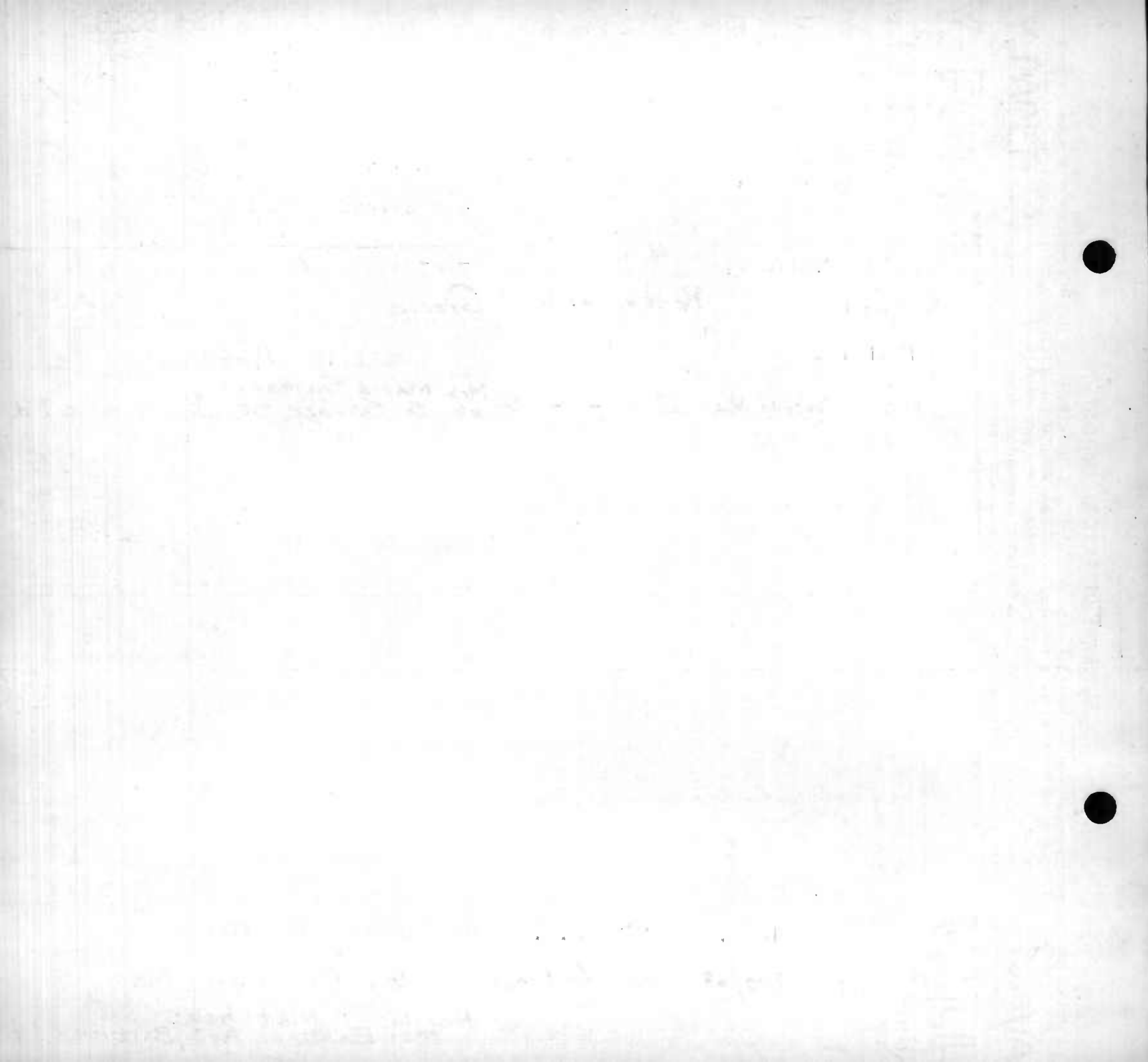
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9316 CERTIFICATE OF DEATH

REG. NO. 68- 9316

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PETER SAMAROS		9/8/68 12 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21224				MARYLAND C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 601 SAVAGE STREET	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-25-91	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Restaurant		Greece	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
DIMNIRIOS			ANDELLIA Angliki		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes World War I		214-20-8584		Mrs. Maria Samaras 601 S. Savage St., Baltimore Md.	
18. 199.0 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic cancer, primary site 3.5 mos	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Intestinal obstruction 2" above 2-3 weeks (C)	
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16 1968 to 9/6 1968, that (I) (we) last saw the deceased alive on 9/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
David L. Jackson M.D.				9/8/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DAVID L. JACKSON M.D.		JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	9/10/68	Greek Orthodox Cemetery Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 12 1968		Nicholas T. Matthews		3021 Eastern Ave., Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

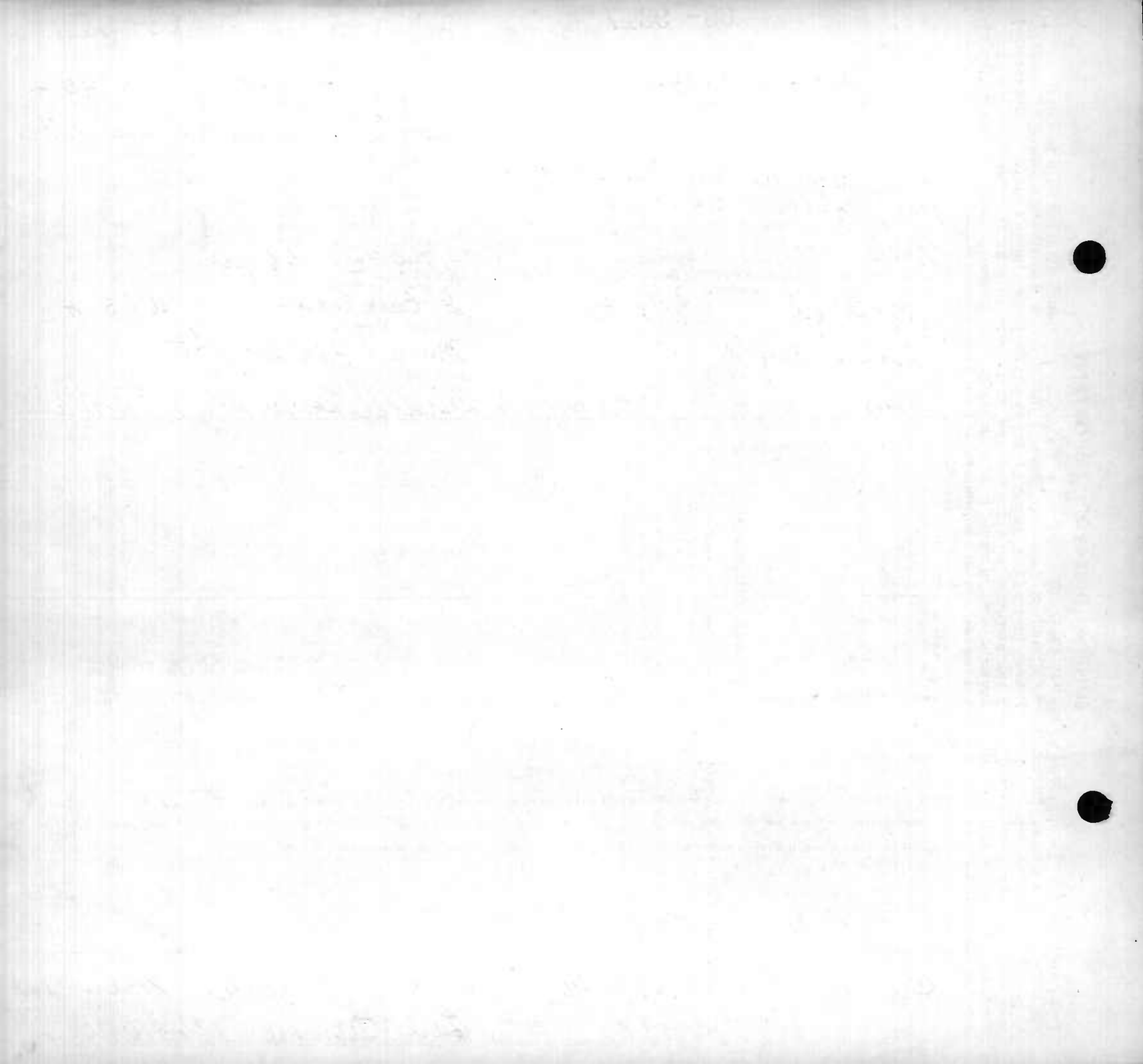
68- 9317

CERTIFICATE OF DEATH

REG. NO.

68- 9317

BIRTH NO.		1. NAME OF DECEASED (Type or Print) DINGLE RICHARD		2. DATE AND HOUR OF DEATH 9-12-1968 3:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2300 Druid Hill Ave. Balto.		5. SEX Male 6. RACE Negro	
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital Inc, 301 St Paul Place, Balto. MD 21202		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1303		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-17-02 9. AGE (In years last birthday) 66 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Porter		11. BIRTHPLACE (State or foreign country) S. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Abel Dingle		14. MOTHER'S MAIDEN NAME Mary Boat Wright	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-7006		17. INFORMANT Birdell Barker Dingle ADDRESS 2300 Druid Hill Ave	
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Extreme Cancer ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cancer oropharynx		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Extreme Cancer (B) DUE TO, OR AS A CONSEQUENCE OF: Cancer oropharynx (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none	
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 8-19-1968 to 9-12-1968 , that (I) (we) last saw the deceased alive on 9-11-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pauline Tingo MD		23B. DATE SIGNED 9-12-68		23C. PHYSICIAN'S NAME (Type) PAULINE TINGO MD	
23D. ADDRESS Mercy Hospital Inc Balto. MD 21202		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/68	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Pk.		24D. LOCATION (City, town, or county) Arbutus Maryland		24E. NAME OF REGISTRAR Robert E. Baltimore	
24F. FUNERAL DIRECTOR Paul Helmore		24G. ADDRESS 1827 W. North Ave		24H. DATE REC'D FOR DEATH CERT SEP 1 1968	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-142		68- 9318		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9318	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Stephen Kovalick		2. DATE AND HOUR OF DEATH 9. 10. 68		11 35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN Fort Howard		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 2-12-18		9. AGE (In years last birthday) 50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Foreman Bethlehem Steel Co.				11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN KOVALICK				14. MOTHER'S MAIDEN NAME MARY TARAPCHAK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 204-09-4912		17. INFORMANT RECORDS: BCH: 4940 EASTERN AVE. BALTO., MD. 21224	
18. 444.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Mesenteric Artery Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 370.2 II				Pancratic		10 Days	
19A. DATE OF OPERATION 3.9.2.68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Gangrene		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-31 19 68 to 9-10 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9. 10 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rolf H. Bessin M.D.				23B. ADDRESS BCH: 4940 EASTERN AVE. BALTO., MD. 21224		23C. DATE SIGNED 9.10.68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave, Dundalk, Md.			

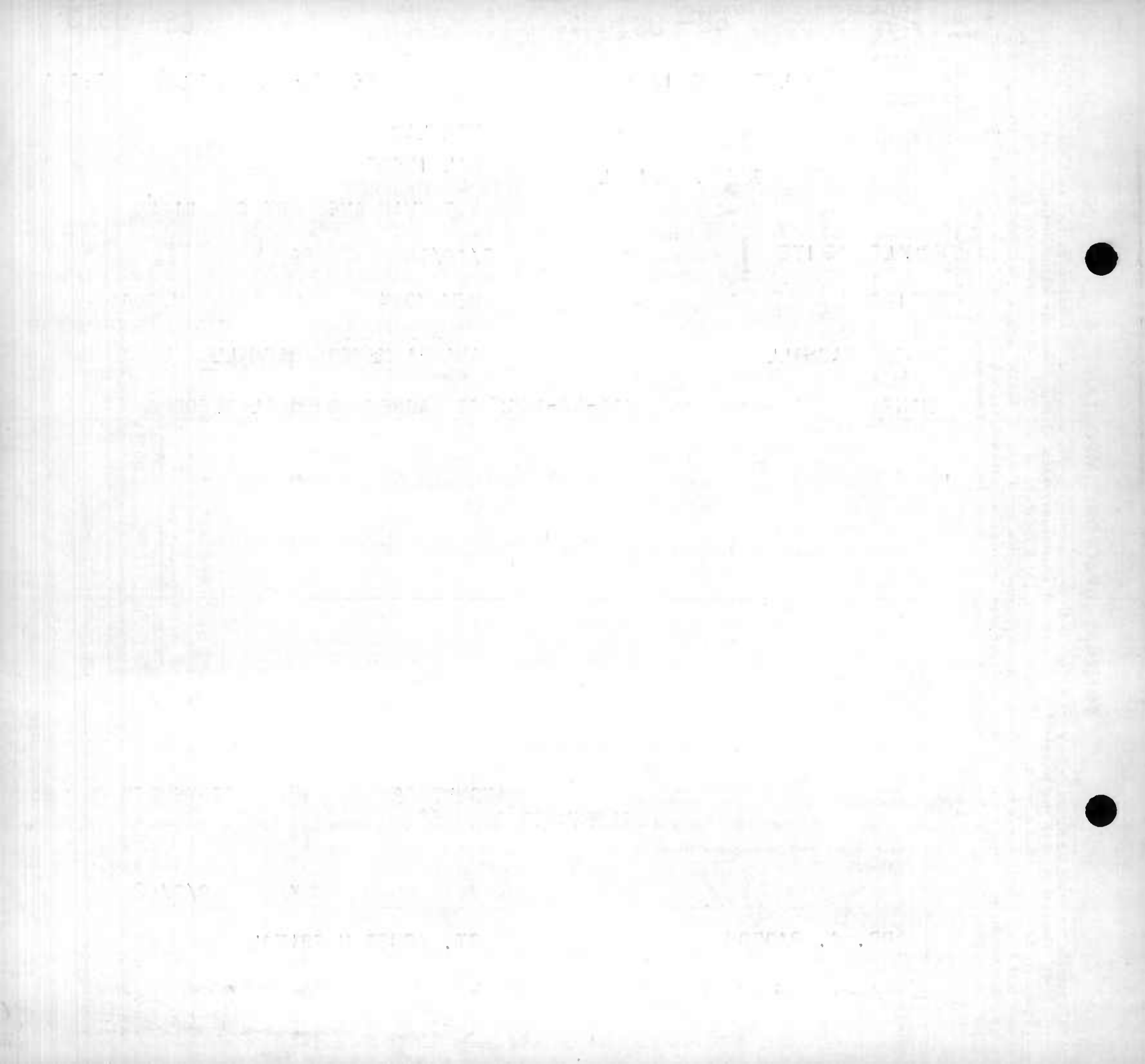
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9319 CERTIFICATE OF DEATH

REG. NO. 68- 9319

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HOLMES, MARIE E.		2. DATE AND HOUR OF DEATH SEPTEMBER 9, 1968 7:30A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 407 SWAN AVE. APT C 21229					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/19/74	9. AGE (In years lost birthday) 93
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - HOME		10B. KIND OF BUSINESS OR INDUSTRY HOUSEKEEPER		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME ROBERT BAGNALL			14. MOTHER'S MAIDEN NAME AMANDA MEYERS BAGNALL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 216-46-1552		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. CAUSE OF DEATH					
<p>239.9 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Mass on abdomen DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 23 19 68 to SEPTEMBER 9 19 68 , that (I) (we) last saw the deceased alive on SEPTEMBER 9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Padron				23B. DATE SIGNED 9/9/68	
23C. PHYSICIAN'S NAME (Type) DR. A. PADRON				23D. ADDRESS ST. AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-68		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cms.	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Taylor - Grayson & Co. Baltimore, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9320

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND H. MYERS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 7, 1968 9:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year September 7, 1968 9:00 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH JULY 7, 1894 10. AGE (In years, lost birthday) 74		E. STREET AND NUMBER 3045 Abell Avenue	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COLONEL - RET.		14B. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	
15. MOTHER'S MAIDEN NAME ORA HENDRICKS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII + II	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Helen A. Myers - 3045 Abell Ave.	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 8, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-11-68	
24C. NAME of CEMETERY or CREMATORY Arlington National Cemetery		24D. LOCATION (City, town, or county) (State) Arlington Virginia	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Fickes	
25C. FUNERAL DIRECTOR Forley-Cronough		ADDRESS J.H. Cottonville Md.	

THE UNIVERSITY OF CHICAGO
CHICAGO, ILLINOIS

OFFICE OF THE
VICE CHANCELLOR

CHICAGO, ILLINOIS

1964

CHICAGO, ILLINOIS

MEC 5531

BALTIMORE CITY HEALTH DEPARTMENT
68- 9321 CERTIFICATE OF DEATH

REG. NO. 68- 9321 4

BIRTH NO. 68-17126		1. NAME OF DECEASED (Type or Print) SMITH, BABY BOY DAVID		2. DATE AND HOUR OF DEATH SEPTEMBER 10, 1968 6:10P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21012 B. COUNTY 52-00		5. CITY OR TOWN ARNOLD	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 404 STEWART AVE.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-68	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 30
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES R. SMITH		14. MOTHER'S MAIDEN NAME ALICE M. LETTAU	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT AVER. BALTO., MD. 21229 ST. AGNES RECORDS-CATONS WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immaturity (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 776X II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 10 1968 to SEPTEMBER 10 1968, that (X) (we) last saw the deceased alive on SEPTEMBER 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John K. Weagly, M.D.		23B. DATE SIGNED 11 Sept 68		23C. PHYSICIAN'S NAME (Type) JOHN WEAGLY, M.D.	
23D. ADDRESS BALTIMORE, MD. 21229		23E. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES.			
24A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		24B. NAME OF REGISTRAR Robert S. Barranco		24C. FUNERAL DIRECTOR ROBERT S. BARRANCO	
24D. DATE OF CREMATION, REMOVAL (Specify) Burial 9-12-68		24E. NAME OF CEMETERY or CREMATORY Ashbury Meth Ch. Cem		24F. LOCATION (City, town, or county) (State) Arnold Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9322

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Gernie Ryan		2. DATE AND HOUR OF DEATH 9/10/68 2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing & Convalescent Center		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? 26-34 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1015 Evansway, Armstead Gardens		5. SEX F		6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/14/91		9. AGE (In years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Shiflett		14. MOTHER'S MAIDEN NAME Alice William	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-2912		17. INFORMANT Gladys Sorg 108 Greenland Av. Trenton, N.J.	
18. 41214 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante mortem CV disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ante mortem generalized		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 4221 II		(B) DUE TO, OR AS A CONSEQUENCE OF: Ante mortem generalized		years	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/7 19 68 to 9/10 19 68 , that (I) (we) last saw the deceased alive on 9/10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN H. MACHT MD				23B. DATE SIGNED 9/11/68	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT MD				23D. ADDRESS 2 E. READ ST Balto Md 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9/12/68		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1216 St. Paul St.		25D. ADDRESS			

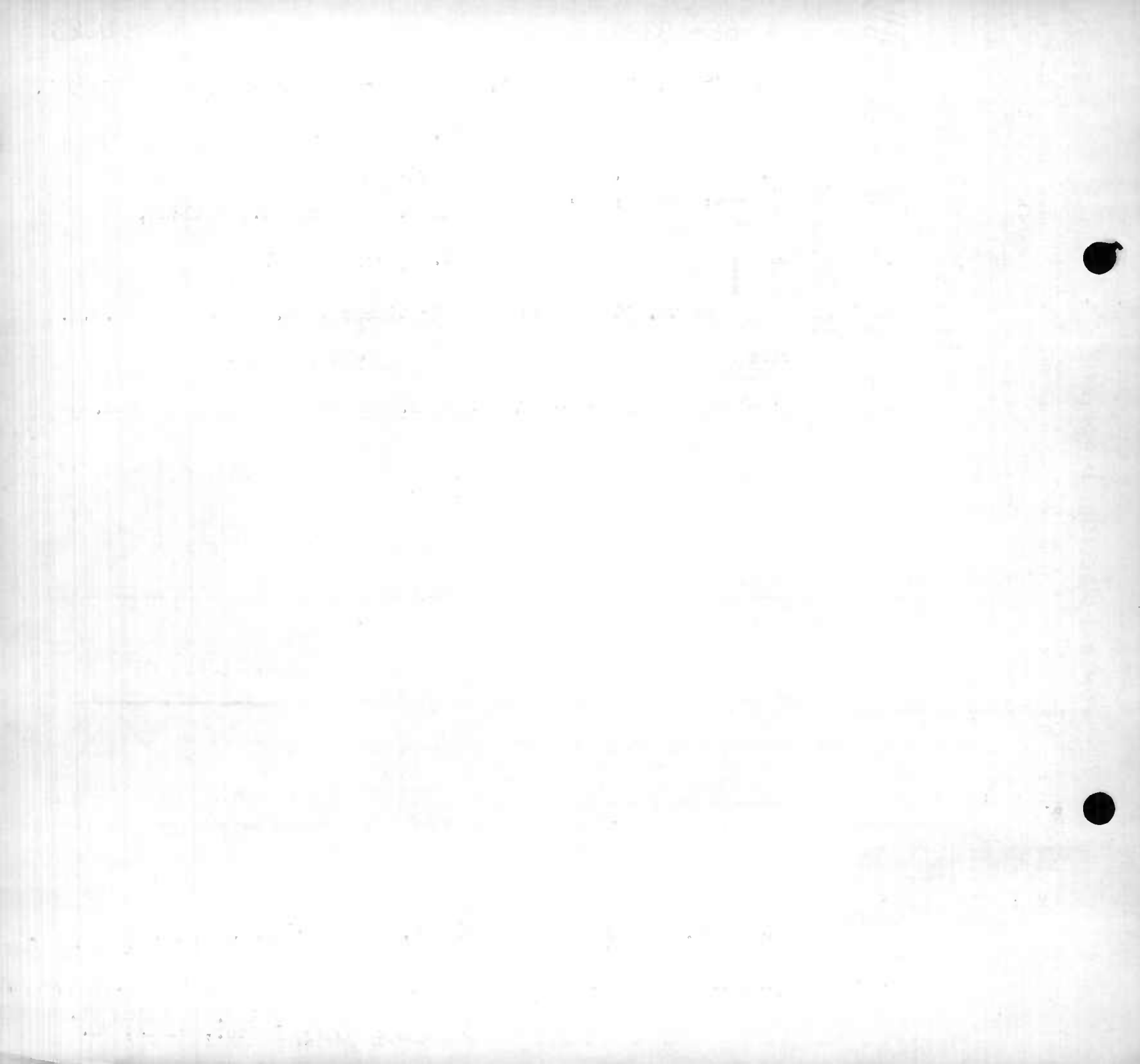
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9323 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9323

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HARRY H. BUSSE , SR.		September 9, 1968 10:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 922 S. Conkling St. Baltimore , 21224 , Md.				A. STATE Md.	
				C. CITY OR TOWN Baltimore	
5. SEX Male				6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Sept. 25, 1889	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Balto. City Worker	
11. BIRTHPLACE (State or foreign country) Baltimore , Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Busse				14. MOTHER'S MAIDEN NAME Bertha Krause	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1910-1916				16. SOCIAL SECURITY NO. 545-05-4557	
17. INFORMANT Anna M. Monroe				ADDRESS Same.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE abdominal hemorrhage minutes. DUE TO, OR AS A CONSEQUENCE OF:					
(B) Advanced Ca of stomach DUE TO, OR AS A CONSEQUENCE OF:					
(C).....					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June 1968 to Aug 1968, that (I) (we) last saw the deceased alive on Aug 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Theodore J. Graziano M.D.				23B. DATE SIGNED Sept 11, 1968.	
23C. PHYSICIAN'S NAME (Type) THEODORE J. GRAZIANO				23D. ADDRESS 1654 E. Belvedere Ave., Balto., 21212, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-12 -68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION 4300 Old Frederick Rd., Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 13 1968			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Charles J. Geiler			
25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9324

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MITCHELL, ELIZABETH

2. DATE AND HOUR OF DEATH

SEPTEMBER 9, 1968

10:55A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

Anne Arundel

5200

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

7913 SEABREEZE DR 21226

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

07/20/85

9. AGE (In years
lost birthday)

83

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FRANK STREB

14. MOTHER'S MAIDEN NAME

CATHERINE STREB

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NONE

16. SOCIAL
SECURITY NO.

215-50-3101

17. INFORMANT

ADDRESS

ST. AGNES HOSPITAL RECORDS

18. 384X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Conjunctive P. Pulmonary
Edema.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

3-94X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Left Kidney A.E. Atrophic Ovary

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 3 1968 to SEPTEMBER 9 1968,
that (I) (we) last saw the deceased alive on SEPTEMBER 9 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hamid

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

09/09/68

23C. PHYSICIAN'S
NAME (Type)

HAMID MEHDIZADEH

23D. ADDRESS

BALTIMORE, MD 21229
ST. AGNES HOSP; CATON & WILKENS AVES.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Sept. 12, 1968 Holy Cross Cemetery

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy. A. A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

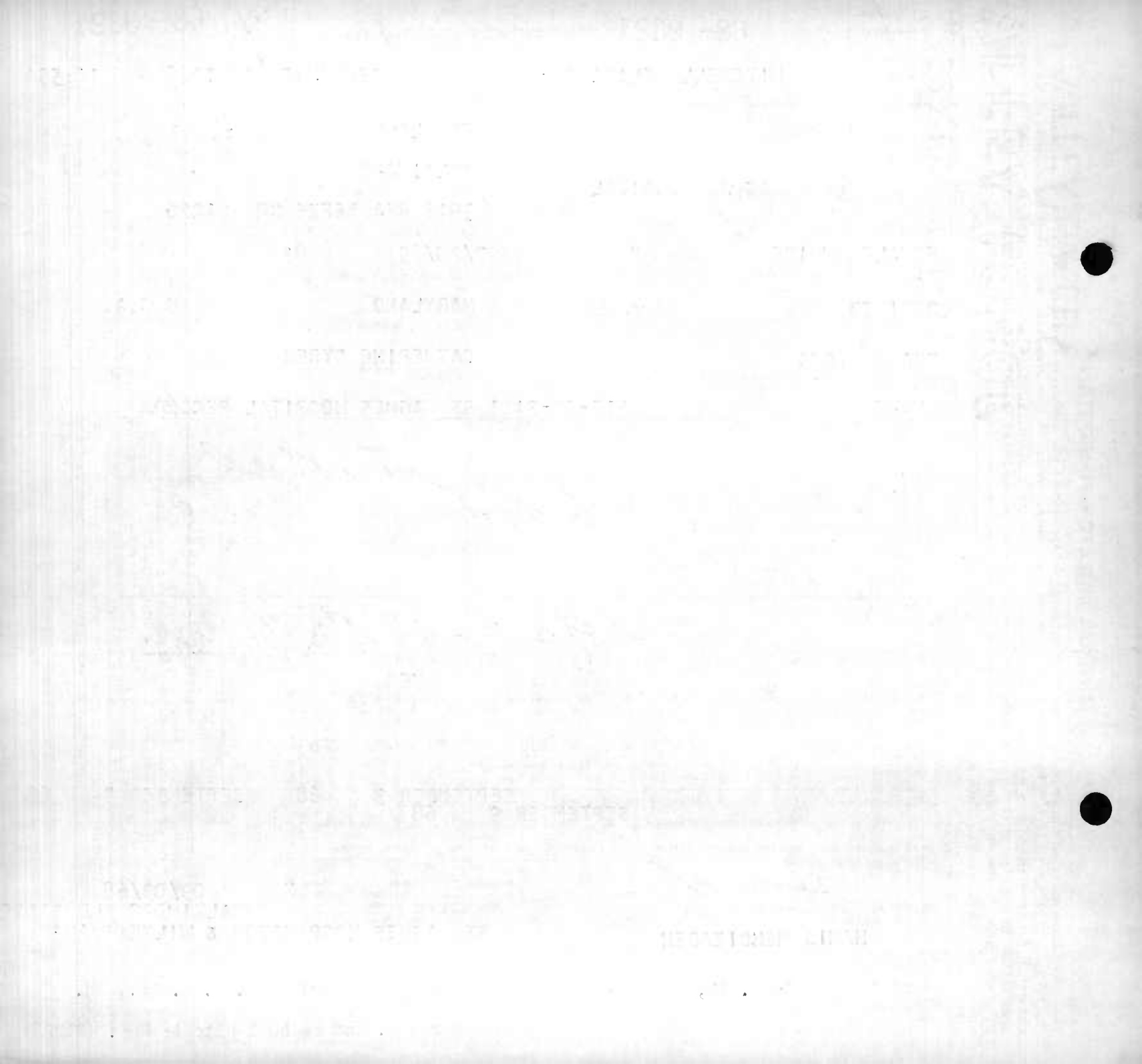
SEP 13 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

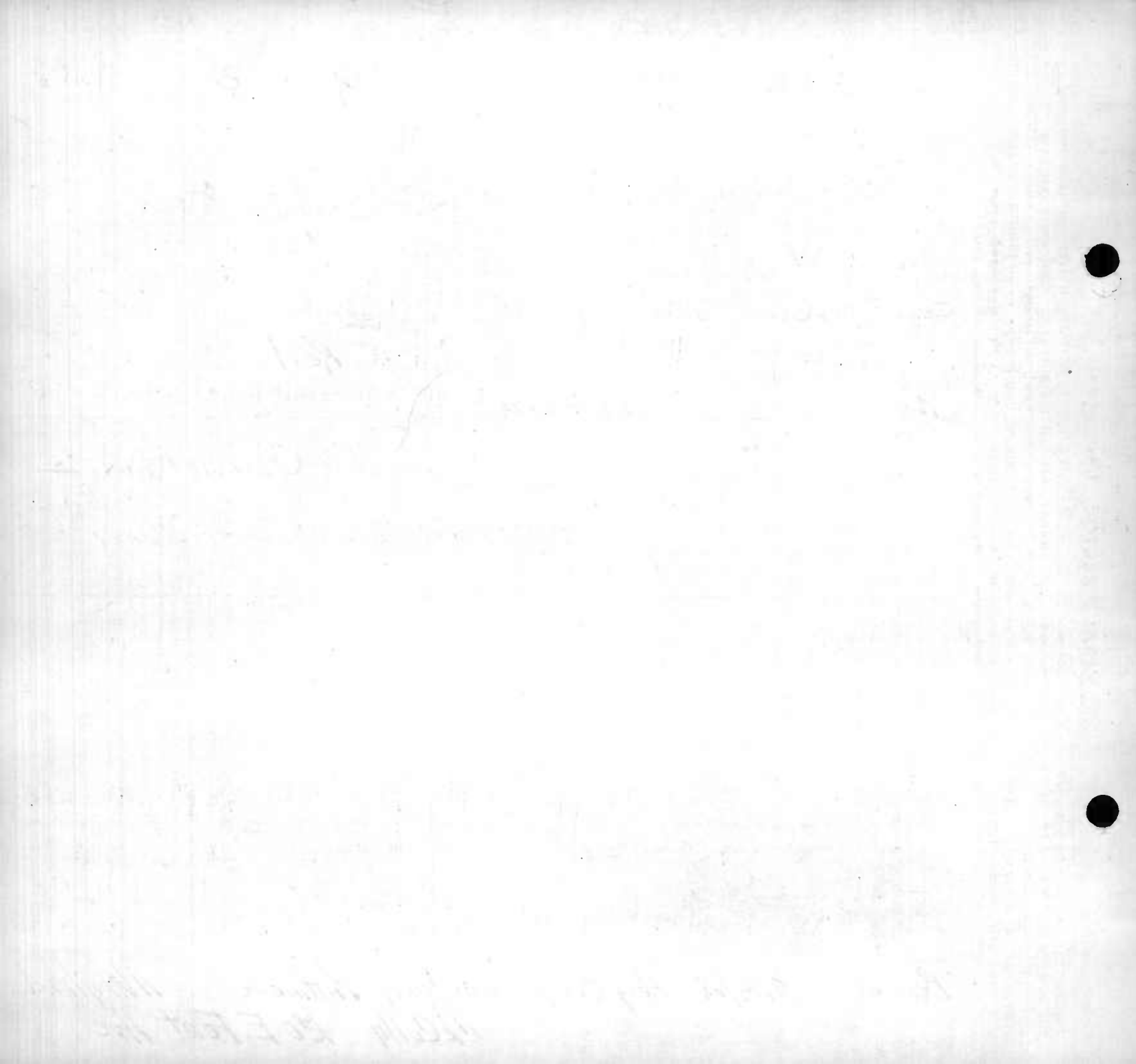
George J. Gon ce 4001 Ritchie Hwy. (21225)



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9325
BIRTH NO.		1. NAME OF DECEASED (Type or Print) John Aro		2. DATE AND HOUR OF DEATH 9-11-68 9:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles General Hospital			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1715 Covington Street		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-11-11	9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Foreman		10B. KIND OF BUSINESS OR INDUSTRY Balto. City Parks		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George H. Aro			14. MOTHER'S MAIDEN NAME Anna Reil		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-0873		17. INFORMANT LYDIA ARO - WIFE - ADDRESS same as pt.	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Possible Cerebral Hemorrhage			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular Disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 473X II			(B) DUE TO, OR AS A CONSEQUENCE OF: 13 days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C).....		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 9 1968 to Sept. 11 1968 , that (I) (we) last saw the deceased alive on Sept. 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 9-11-68	
23C. PHYSICIAN'S NAME (Type) W. KOHN, M.D. (PRIVATE PHYSICIAN)				23D. ADDRESS North Charles Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9/14/68	24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP. 13 1968		25B. NAME OF REGISTRAR Robert E. Stanley		25C. FUNERAL DIRECTOR McCully ADDRESS 130 E. Fort Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9326

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEO M. TEWEY

2. DATE AND HOUR OF DEATH

SET. 9 - 1968 7.00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)LUTHERAN HOSPITAL OF
MARYLAND

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

1801 Woodside Avenue

5. SEX

male

6. RACE

white

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6-3-1903

9. AGE (In years
last birthday)

65

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John L. Tewey

14. MOTHER'S MAIDEN NAME

Elizabeth Luebehusen

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Mrs. John Magrogan 1801 Woodside Ave. 21227
from chart

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cancer, secondary

(B)

DUE TO, OR AS A CONSEQUENCE OF:

in liver, primary

(C)

undetermined.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/20 1968 to 9/9 1968,
that (I) (we) last saw the deceased alive on 9/9 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. S. Ming

DEGREE

Attending ☐Med.
Director ☐Staff ☒

23B. DATE SIGNED

9/9/68

23C. PHYSICIAN'S
NAME (Type)

CHEE SHYWE MING

DEGREE

23D. ADDRESS

Lutheran Hospital of Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial,

24B. DATE 9-12-68

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, City, Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1968

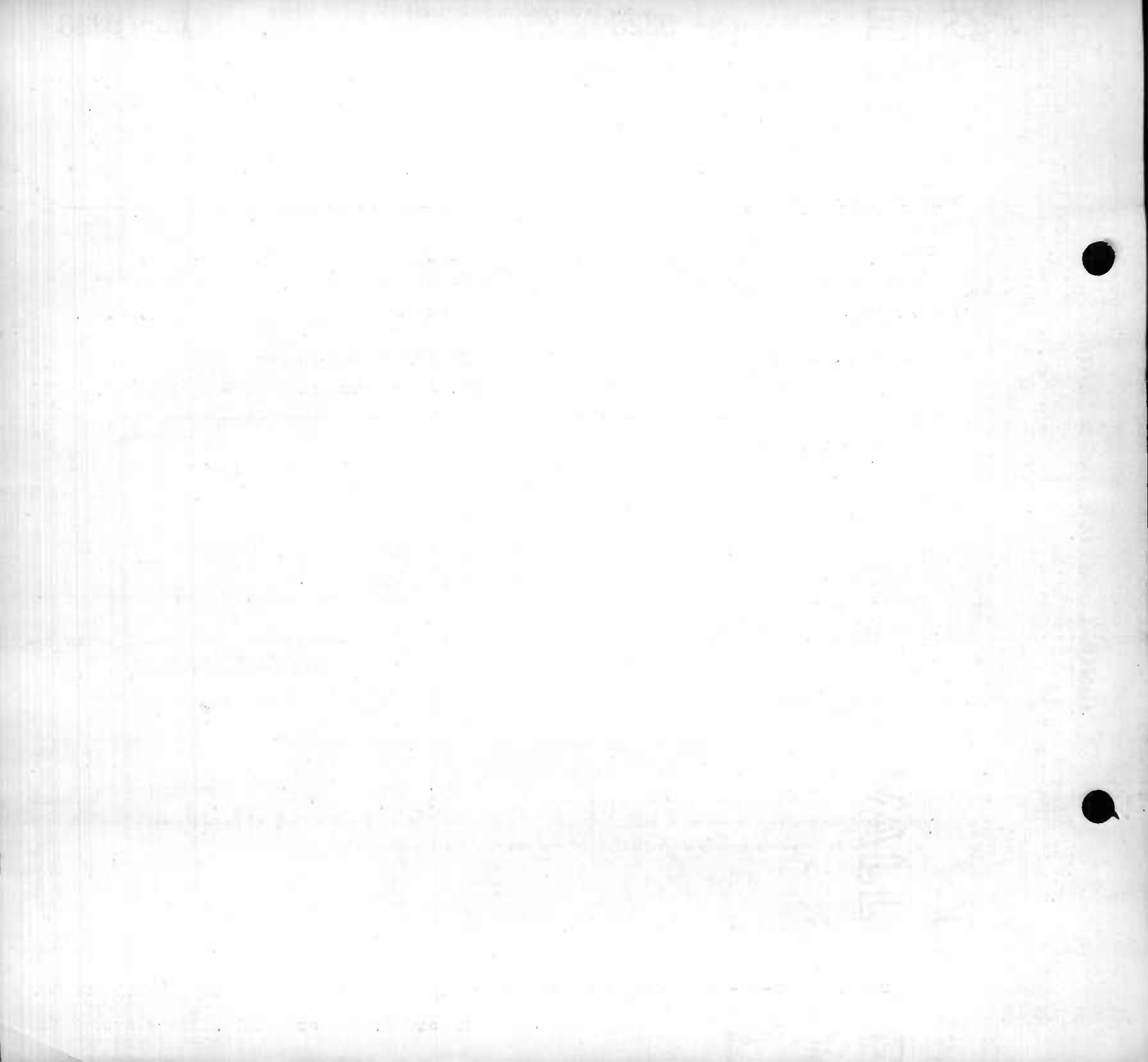
25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard 4107 Wilkens Ave. 21229



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9327 CERTIFICATE OF DEATH

REG. NO.

68- 9327

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ernest Kendrel Hogge

2. DATE AND HOUR OF DEATH

Sept. 9, 1968

3:38 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)US Public Health Service Hospital
3100 Wyman Park Drive4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE B. COUNTY

Va.

V-43

C. CITY OR TOWN

Providence Forge

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

5. SEX
M6. RACE
W7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5/15/25

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Fisherman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Kenny Hogge

14. MOTHER'S MAIDEN NAME

Ollie Hornsby

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

USA 1944-1946

16. SOCIAL
SECURITY NO.

231-22-4470

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Cryptococcal meningitis

Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

Hodgkin's disease

Years

(C) _____

MEDICAL CERTIFICATION

134.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

no

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug. 25 1968 to Sept. 9 1968,
that (I) (we) last saw the deceased alive on Sept. 9 1968 and that in (I) (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. D. Bellamy, Sr.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9/10/68

23C. PHYSICIAN'S
NAME (Type)

Murlyn D. Bellamy, Sr. Surgeon

DEGREE

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-13-68

24C. NAME OF CEMETERY or CREMATORY

Bradley Cemetery

24D. LOCATION

(City, town, or county)

New Kent County, Virginia

1 State

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1968

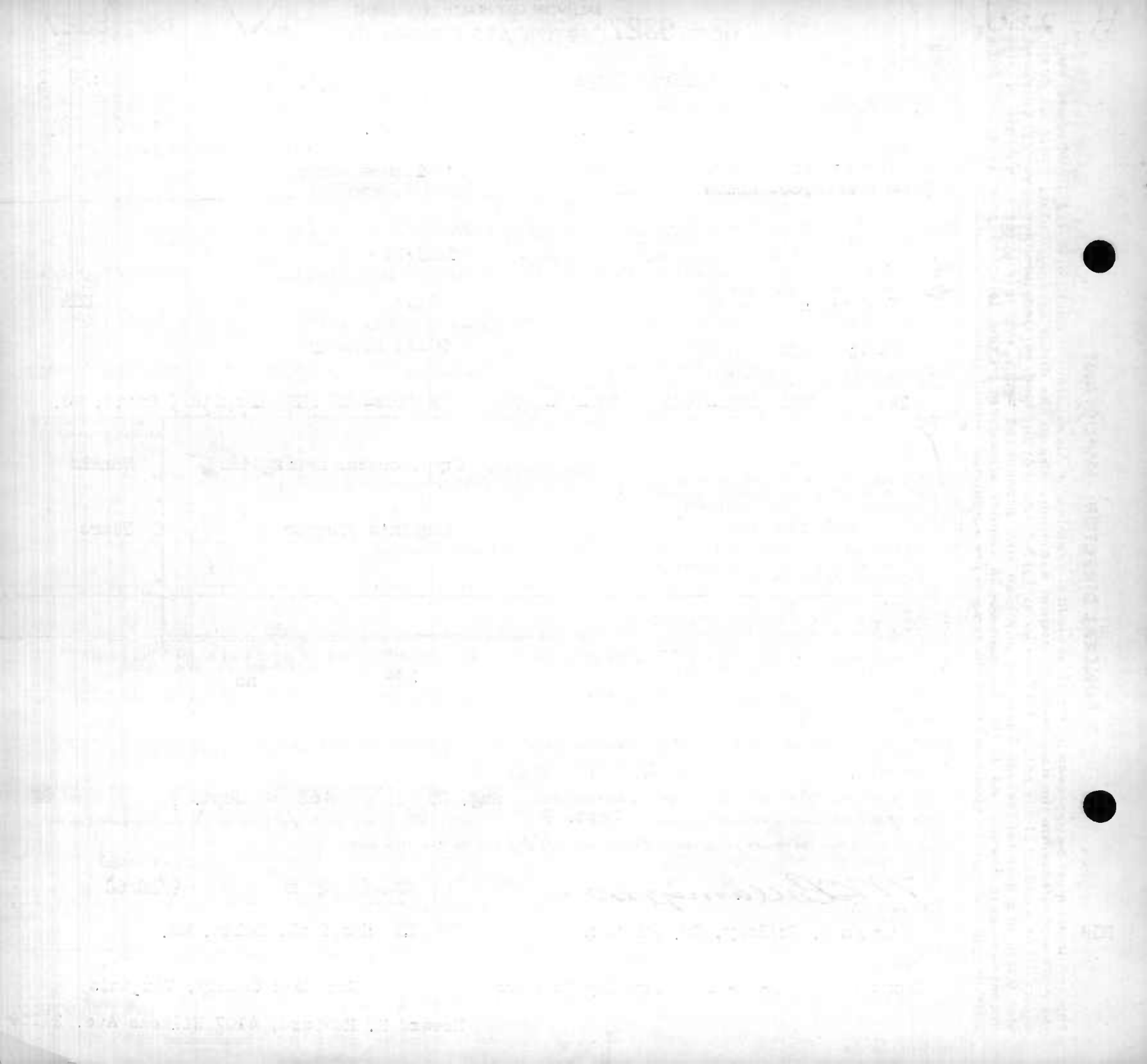
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

ADDRESS

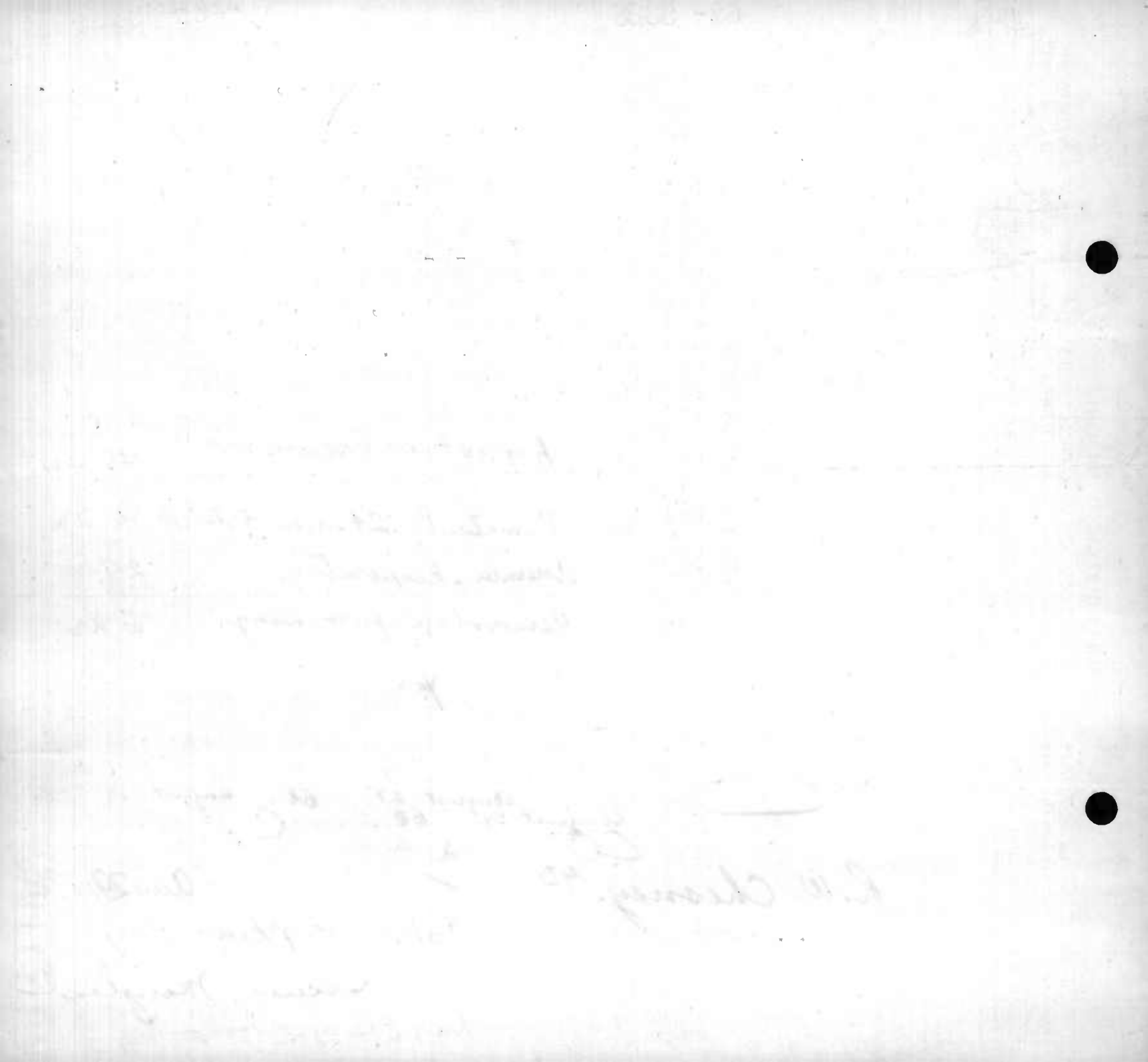
Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Charles C. Md.</i>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <i>68-9328</i>
1. NAME OF DECEASED (Type or Print) Baby Girl Brown		2. DATE AND HOUR OF DEATH August 29, 1968 6:50 p. m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Charles C. CITY OR TOWN LaPlata D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Star Route #3		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-68	9. AGE (In years lost birthday) 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Frank Ambrose Brown		
14. MOTHER'S MAIDEN NAME Martha H. Wheeler		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. 486 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity 24 weeks gestation 96 hrs		
		(B) DUE TO, OR AS A CONSEQUENCE OF: Anemia, Respiratory 24 hrs		
		(C) Hemorrhage from Lung 6 hrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 763.5 II				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from August 27 1968 to August 29 1968 , that (I) (we) lost saw the deceased olive on August 29 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE R. W. Chesney MD		23B. DATE SIGNED Aug 29, 1968		23C. PHYSICIAN'S NAME (Type) R.W. Chesney
23D. ADDRESS Johns Hopkins Hosp		24A. BURIAL CREMATION, REMOVAL (Specify)		
24B. DATE		24C. NAME OF CEMETERY or CREMATORY Holy Ghost		24D. LOCATION (City, town, or county) (State) Isles, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Henry E Berry Pomonkey Md



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG NO.

68- 9329

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Cumberland, Kathryn A. MRS.		2. DATE AND HOUR OF DEATH 9-11-68 9:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO. C. CITY OR TOWN Acton D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION House In The Pines Belvedere		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90525 W. Belvedere		E. STREET AND NUMBER 3011 Acton Rd	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/1884	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) ARIZONIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Hughes		14. MOTHER'S MAIDEN NAME Mary Ludwig	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs Irene Knight ADDRESS Jane	
18. 436.914-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Corbular Venular Ac. Inf. (B) DUE TO, OR AS A CONSEQUENCE OF: Astoria seborrheic (C) Draletos mollities		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 8 days years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION 9-11-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-5 1968 to 9-11 1968 , that (I) (we) last saw the deceased alive on 9-10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David F. Miller		23B. DATE SIGNED 9-11-68		23C. PHYSICIAN'S NAME (Type) David F. Miller	
23D. ADDRESS 9115 Reisterstown Rd. - Owings Mills, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-11-68	24C. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Garden		24D. LOCATION (City, town, or county) (State) Bel Air Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Chas F. KHAMUSON ADDRESS 8802 HARTFORD RD	

From the ... of ...
John F. Kennedy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9330 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 5330

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN DAVID JACKSON		2. DATE AND HOUR OF DEATH September 12/1968 1:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10B. KIND OF BUSINESS OR INDUSTRY READY BUILT PROD.		11. BIRTHPLACE (State or foreign country) S. CAROLINA	
13. FATHER'S NAME WILLIE JACKSON				14. MOTHER'S MAIDEN NAME PEARL BROCKINGTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT BROTHER ADDRESS 965 Lythurst St	
18. 446.5 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 467.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 72.6				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1:35 AM 9/12/68 8/25/1968	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 3 19 68 to September 12 19 68 , that (I) (we) last saw the deceased alive on September 12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique Elbertsen MD				23B. DATE SIGNED Sept 12/68	
23C. PHYSICIAN'S NAME (Type) RICHARD K. GUNDEY MD				23D. ADDRESS 2 W. UNIVERSITY PKWY, 18	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-68		24C. NAME OF CEMETERY or CREMATORY Laurel Mem. Park	
24D. LOCATION (City, town, or county) (State) Laurel, Md		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Morton E. Dye H.F.H.		ADDRESS 1701 Laurens St	

off

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9331 CERTIFICATE OF DEATH

REG. NO.

68- 9331

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>BERNICE DARNELL MILLER</i>		2. DATE AND HOUR OF DEATH <i>12 SEPT. 1968</i> <i>12 20 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>M.D.</i> B. COUNTY <i>BALTO.</i>		5. CITY OR TOWN <i>BALTO.</i> D. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 UNIV. OF MARYLAND HOSPITAL</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>923 Harlem Ave 21217</i>	
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/23/19</i>	9. AGE (In years last birthday) <i>51</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>M.D., Balt.,</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Maurice Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Elsie Marie Jones</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-12-0904</i>		17. INFORMANT <i>Mr. James B. Miller</i>	
18. <i>150X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CARCINOMA OF THE ESOPHAGUS E</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTASES</i>		19. CAUSE OF DEATH <i>6 mos.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>150X II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10 SEPTEMBER 19 68</i> to <i>12 SEPTEMBER 19 68</i> , that (I) (we) last saw the deceased alive on <i>11 SEPTEMBER 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jean M. Jackson, M.D.</i>				23B. DATE SIGNED <i>12 September 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>JEAN M. JACKSON, M.D.</i>				23D. ADDRESS <i>Univ. of Md. Hospital Balto. Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-16-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Balt. Nat'l Cem.</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
24G. FUNERAL DIRECTOR <i>Mocton & Dyett F.H.</i>		24H. ADDRESS <i>1701 Laurens St.</i>		24I. DATE <i>SEP 13 1968</i>	

1840

1840

1840

1840

1840

1840

1840

1840

1840

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9332 CERTIFICATE OF DEATH

REG. NO. 68- 9332

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM CHAMBERS

2. DATE AND HOUR OF DEATH

Sept 11, 1968 6:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital of Baltimore Inc
42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2017 NORTHEAST AV. 21227.

5. SEX

M

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

6-4-84

9. AGE (In years last birthday)

84

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired.

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

U.S.A. Calvert Co, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Levi Chambers

14. MOTHER'S MAIDEN NAME

Diana Chambers

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

214-16-3814

17. INFORMANT

Miss Hazel Chambers 2017 N. East Ave

ADDRESS

18. 412.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

PNEUMONIA

(B) DUE TO, OR AS A CONSEQUENCE OF:

C.V.A.

(C) DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

24 hrs

?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Acute Renal failure

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 10 19 68 to Sept 11 19 68, that (I) (we) last saw the deceased alive on Sept 11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Laventman

MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE, SIGNED

Sept 11, 68

23C. PHYSICIAN'S NAME (Type)

JAME LAVENTMAN MD

23D. ADDRESS

SINAI HOSPITAL OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

9-14-68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State)

Arbutus, Md

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1968

25B. NAME OF REGISTRAR

Robert E. [unclear]

25C. FUNERAL DIRECTOR

Morton E. Dyett F.H. 1701 Laurens St

ADDRESS

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9333

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 9333

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Annie Young</u>		2. DATE AND HOUR OF DEATH <u>September 10, 1968 11:05 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore, Inc.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>3924 Reisterstown Road</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1917</u>	9. AGE (In years lost birthday) <u>51</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Edge Field, S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John H. Garnett</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE GARNETT</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-28-2083</u>		17. INFORMANT <u>James Young</u> ADDRESS <u>3924 Reister Town Rd.</u>	
18. <u>493X1-250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Asthmatic Attack</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Bronchial Asthma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 years</u> <u>10 years</u>	
19A. DATE OF OPERATION <u>2 -</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>Sept 10 1968</u> to <u>Sept 10 1968</u> , that (I) (we) <u>never</u> saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE <u>Barry Green M.D.</u> OEGREE	
23B. DATE SIGNED <u>9/11/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Barry Green, M.D.</u> OEGREE		23D. ADDRESS <u>Sinai Hospital of Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-16-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>BA lto. NAT.</u>	
24D. LOCATION (City, town, or county) (State) <u>BA lto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>MORTON J. DYETT</u>		ADDRESS <u>1701 LAURENS</u>			

1-25-1917

Edg. Field, 2C

Farms Farm II

Factory

John H. Carver II

James Jones 3334 Jones St

Home - 1001 1001
Balto. Md
Balto. Md
Balto. Md

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9334

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KATE L. MYERS				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 10 68 9:50 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital D.O.A.				3. DATE PRONOUNCED DEAD Month Day Year Hour September 10, 1968 9:50 p.m.			
6. SEX Female				7. RACE Colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7-21-1894				10. AGE (In years lost birthday) 74		11. BIRTHPLACE (State or foreign country) Howard Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John E. White		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Martha Ellen White				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Nellie Waddy				ADDRESS 538 N. Payson			
19. 412.4 + 174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Breast cancer				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Breast cancer				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
22A. DATE OF OPERATION				22B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. DATE SIGNED Sept. 11, 1968							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-14-68		24C. NAME OF CEMETERY or CREMATORY Hopkins Chapel		24D. LOCATION (City, town, or county) (State) Highland, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR MORRIS + DGETT		ADDRESS 1701 LAURENS	

P-21-1894

Howard G. M.

U.S.A.

John F. White

Martin E. White

Willie W. White 238 N. 1st St.

Barrett P-14-18 Hopkins Chapel, Highland, Mo.

Harmon - Dept. 1st

FUNERAL DIRECTOR: IMPORTANT

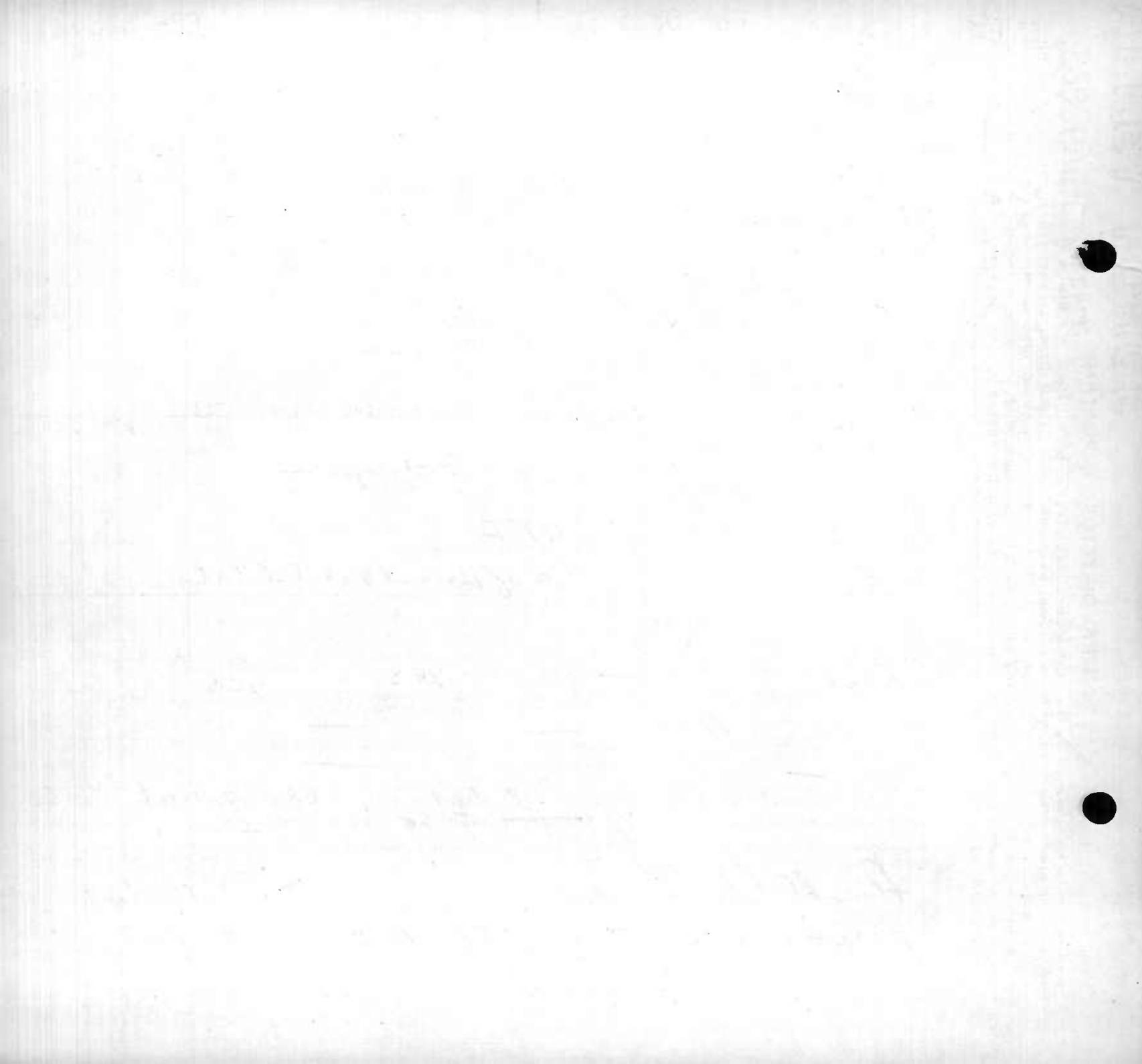
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9335

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JESSE FIELDS		2. DATE AND HOUR OF DEATH 10 Sept 1968 3:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 813 Tessier Street 21201	
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/16	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Brad Allen		14. MOTHER'S MAIDEN NAME Ole Anderson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Bernice Mc Crae 1712 Madison Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH GO sepsis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: UTI (B) DUE TO, OR AS A CONSEQUENCE OF: Ca of Breast & debilitation (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 170 X II					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —		21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? —		22. I certify that (I) (this hospital) attended the deceased from 8 Sept 1968 to 10 Sept 1968 , that (I) (we) last saw the deceased alive on 9/6 Sept 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Frank C. Arnett		23B. DATE SIGNED 10 Sept 1968		23C. PHYSICIAN'S NAME (Type) FRANK C. ARNETT	
23D. ADDRESS 550 N. BROADWAY BALT. MD.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968	
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. 1735 Harford Ave.		ADDRESS	



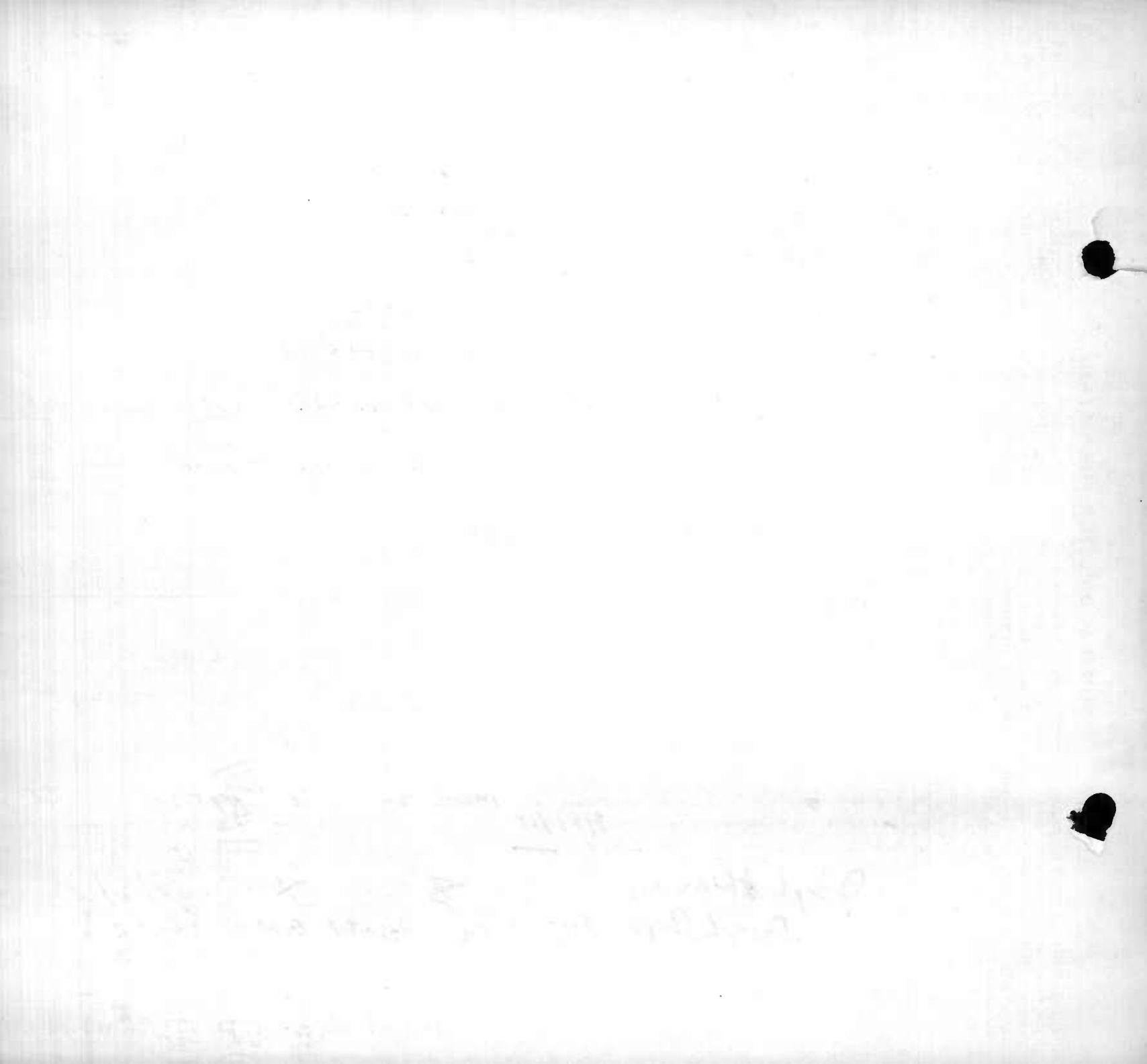
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9336 CERTIFICATE OF DEATH

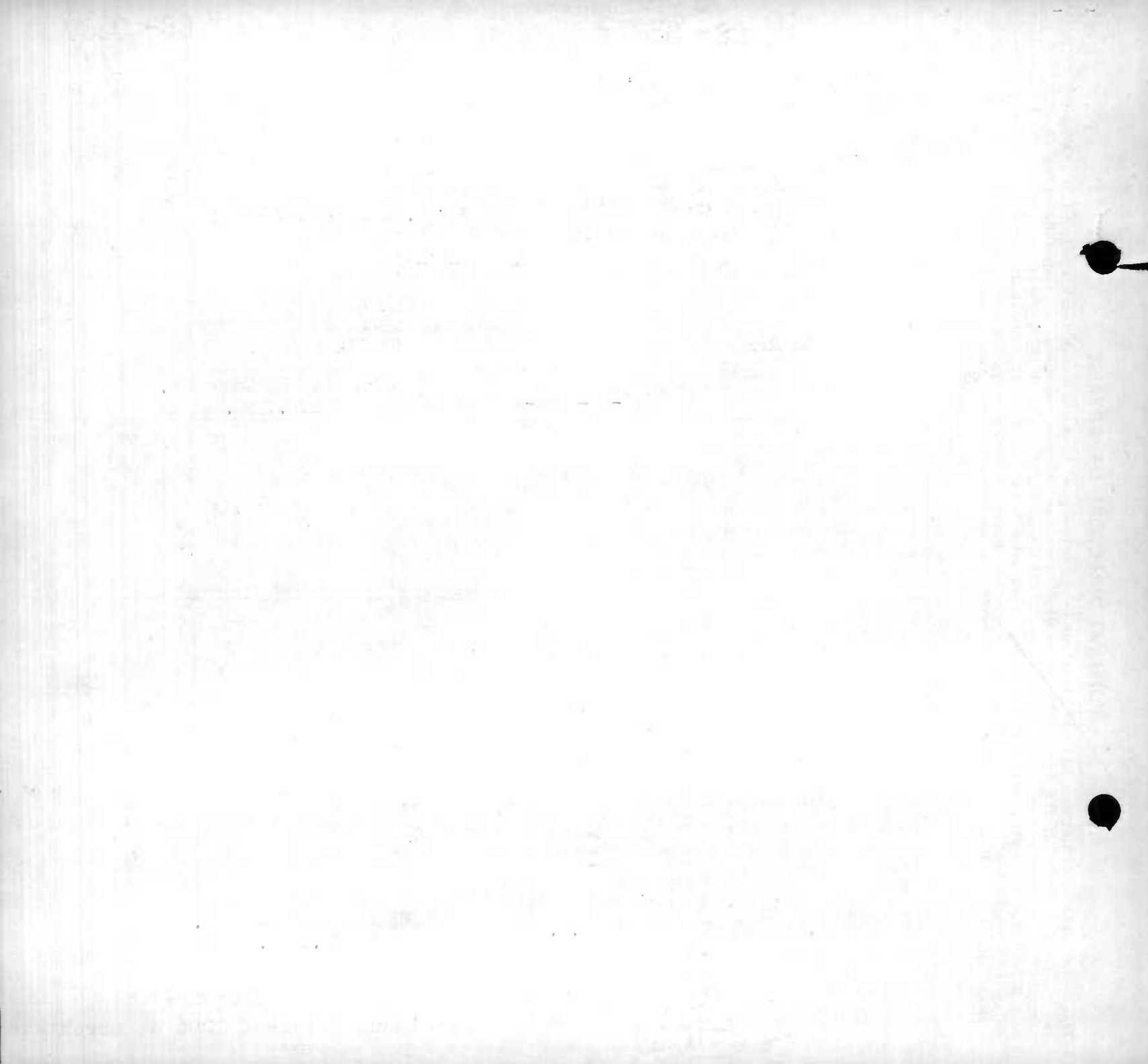
REG. NO. 68- 9336

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FLORENCE JEFFERSON		2. DATE AND HOUR OF DEATH 9/12/68 12 05 A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL 12 BALTO 15 MD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4302 Pimlico Rd	
5. SEX Female	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 JUL 1875	9. AGE (In years lost birthday) 93	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME RUFUS JEFFERSON		14. MOTHER'S MAIDEN NAME Henretta ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-32-023A		17. INFORMANT IRENE LOGAN	
				ADDRESS 4302 PIMLICO Rd	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Coronary Occlusion (B) ASEVD (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (s) (this hospital) attended the deceased from March 20 19 68 to Sept 12 19 68 , that (s) (we) last saw the deceased alive on 8/21/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Shear M.D.				23B. DATE SIGNED 9/12/68	
23C. PHYSICIAN'S NAME (Type) Joseph Shear MD		23D. ADDRESS SINAI Hospital C.M.C. CLINIC			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-16-68		24C. NAME OF CEMETERY or CREMATORY MT CALVARY CEMETERY	
24D. LOCATION AA, Co. Md		24E. FUNERAL DIRECTOR Marshall W. Jones, JR.		24F. ADDRESS 1735 Harford Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9337	
BIRTH NO.				68-9337	
1. NAME OF DECEASED (Type or Print) JAMES H. MASON				2. DATE AND HOUR OF DEATH 9-9-68 20 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN BALTIMORE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 313 E. 24th STREET 21218	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-20-93	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WALTER			14. MOTHER'S MAIDEN NAME STACIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-03-3890-A		17. INFORMANT BCH: 4940 EASTERN AVE. RECORDS: BALTO., MD. 21224
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Squamous cell carcinoma of lung. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
19. 163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-2 19 68 to 9-9 19 68, that (I) (we) last saw the deceased alive on 9-9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE R. Christopher Stucky M.D.				23B. DATE SIGNED 9-9-68	
23C. PHYSICIAN'S NAME (Type) R. CHRISTOPHER STUCKY M.D.				23D. ADDRESS BCH 4940 EASTERN AVE. BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore Md		24E. NAME OF REGISTRAR Robert E. Stucky		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W north Ave	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9338 **CERTIFICATE OF DEATH** REG. NO. 68- 9338

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Connaway, Harry</i>		2. DATE AND HOUR OF DEATH <i>Sept 12, 1968 8 30A M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>48 MARYLAND GENERAL HOAPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Balto</i> B. COUNTY <i>11-04</i>		C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>m</i> 6. RACE <i>N</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/21/01</i> 9. AGE (In years lost birthday) <i>67</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-03-2939</i>		17. INFORMANT <i>Mrs Venie Butler, same</i> ADDRESS	
18. <i>410.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac arrest secondary to arrhythmia</i> (B) <i>Cardiogenic shock 2° to massive MI - 24hrs</i> (C) <i>A SCVD - Hypertension</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 11 19 68</i> to <i>8 30AM</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8 30AM Sept 12 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A S Glushakov</i>		23B. DATE SIGNED <i>Sept 12, 1968</i>			
23C. PHYSICIAN'S NAME (Type) <i>A S GLUSHAKOV</i>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/16/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md</i>			
25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>A Halstead</i> ADDRESS <i>1206 W North Ave</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9339 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9339

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JESSIE BR ROOKS		2. DATE AND HOUR OF DEATH 11 Sept 1968 5:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF Maryland Hosp.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1016 Booth St.		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/99	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 217-01-4808		17. INFORMANT Mabel Mitchell
18. 1519 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA OF STOMACH AND CEREBRAL VASCULAR ACCIDENT			ADDRESS 1016 Booth St APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION —		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that the (this hospital) attended the deceased from 3 Sept 1968 to 11 Sept 1968 , that we (we) last saw the deceased alive on 11 Sept. 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE Dale P. Baker MD				23B. DATE SIGNED 11 Sept 1968	
23C. PHYSICIAN'S NAME (Type) DALE P. BAKER MD				23D. ADDRESS UNIV. OF MARYLAND HOSPITAL - BALT. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/68		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Balt. Md		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR William J. Edwards	
25C. FUNERAL DIRECTOR William J. Edwards		ADDRESS 3199 Lehigh St			

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

52-59-16
CEK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-400				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9340	
1. NAME OF DECEASED (Type or Print) ERNEST HALL				2. DATE AND HOUR OF DEATH 9/11/68 6⁰⁰ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE				6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-23-32				9. AGE (In years lost birthday) 36		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ERNEST HALL				14. MOTHER'S MAIDEN NAME REGINA HALL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMATION RECORDS: 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224	
18. 0119 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) pulmonary embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 6 months				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pulmonary embolism (B) pulmonary tuberculosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed 6 months	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 002.1 II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. YES? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9/7/68 19 to 9/11/68 19, that (1) (we) lost saw the deceased olive on 9/11/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David Acker M.D. DEGREE				23B. DATE SIGNED 9/11/68		23C. PHYSICIAN'S NAME (Type) DAVID ACKER M.D. DEGREE	
23D. ADDRESS 4940 Eastern Ave Baltimore							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Cedar Hill Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Jarman		25C. FUNERAL DIRECTOR McGraws Funeral Home 319 N. Lombard St		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9341

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 9341

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Bernadine Preston		2. DATE AND HOUR OF DEATH Sept 10, 1968 6 35 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland Baptist Home			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
2801 Rayner Ave			E. STREET AND NUMBER 1029 N. Caroline St		
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 12, 1899	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME John H. Preston		
14. MOTHER'S MAIDEN NAME Mary -			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT James Preston 1019 N. Woodington Rd		
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. NEVD.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 3 day (B) DUE TO, OR AS A CONSEQUENCE OF: 5 yrs (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 1966 to Sept. 1968 , that (I) (we) last saw the deceased alive on Sept 9, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. Poik				23B. DATE SIGNED 9/13/68	
23C. PHYSICIAN'S NAME (Type) William B. Poik				23D. ADDRESS 1141 N. Feltz Ave Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Joseph H. Russ 2222 W. North Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9342 CERTIFICATE OF DEATH

REG. NO. 68- 9342

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HOWARD GEORGE SCHEIDLE SR.		2. DATE AND HOUR OF DEATH SEP. 11, 1968 1:15 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 5521 FERNPARK AVE.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/1915	9. AGE (In years last birthday) 52	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - Paper Factory			11. BIRTHPLACE (State or foreign country) MARYLAND, BALTO		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HENRY SCHEIDLE			14. MOTHER'S MAIDEN NAME HAUFLEMEYER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no unknown) (If yes, give war or dates of service) WW 1 - ARMY			16. SOCIAL SECURITY NO. YES		17. INFORMANT Howard Scheidle, Jr. - 5521 Fernpark Avenue UTAI RUANGWIT, M.D. - FRANKLIN SQ. HOSP.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 422.21 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 433.0 II			CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (B) Severe dehydration DUE TO, OR AS A CONSEQUENCE OF (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT 9 1968 to SEPT 11 1968 , that (I) (we) last saw the deceased alive on Sept. 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Utai Ruangwut, M.D.				23B. DATE SIGNED Sept 11, '68	
23C. PHYSICIAN'S NAME (Type) UTAI RUANGWIT, M.D.				23D. ADDRESS FRANKLIN SQUARE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ellsworth Armacost	
				ADDRESS 4600 Liberty Hghts. Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9343 CERTIFICATE OF DEATH

REG. NO. 68- 9343

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Heath, Emma K.</i>		2. DATE AND HOUR OF DEATH <i>8/11 8:17 am</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3-3-1894</i>		9. AGE (In years last birthday) <i>84</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>Kelly</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Dorothy B. Jones</i> ADDRESS <i>1618 Charlotte Ave #24</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Long colic + Diarrhea & disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cardiac changes, etc.</i> (B) <i>Several arteriosclerosis,</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>—</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>15 "</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1940</i> to <i>Sept 10</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>Sept 6</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kurt Lew</i>				23B. DATE SIGNED <i>9/11/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>KURT LEW, M.D.</i> <i>3103 N. Charles Street</i>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-16-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Louisa Park</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. STATE (State) <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Elsworth ARMACOST - 4600 Liberty Hts</i>	

Handwritten text, possibly a signature or name, located in the upper left quadrant of the page.

Handwritten text, possibly a signature or name, located in the lower right quadrant of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9344

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9344

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGIA B. LIND

2. DATE AND HOUR OF DEATH

Sept. 11, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43

SOUTH BALTO GENERAL HOSP.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

MD.

BALTO

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

4604 Prudence Street

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-18-1913

9. AGE (In years
last birthday)

55

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

AT HOME

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM HENRY ENGLE

14. MOTHER'S MAIDEN NAME

DANIELS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ALLAN G. LIND-4604 PRUDENCE ST # 26

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

GIT Hemorrhage

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 day

(B) DUE TO, OR AS A CONSEQUENCE OF:

Marginal ulcer and
Esophageal varices

(C) PORTAL cirrhosis

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10 Sept 19 68 to 11 Sept 19 68,
that (I) (we) last saw the deceased alive on 11 Sept 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

NE Mendelsohn M.D.

DEGREE

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

11 Sept 68

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

9-14-68

24C. NAME of CEMETERY or CREMATORY

WOODLAWN CEMETERY

24D. LOCATION

(City, town, or county)

BALTO MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. PLACE OF DEATH (If in Baltimore City, give exact location)

4604 Prudence St - 4604 Liberty
Cimacoch Funeral Home Hgts
Bk. Cr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9345 CERTIFICATE OF DEATH

REG. NO. 68- 9345

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Rosaria Alberti		2. DATE AND HOUR OF DEATH 9-11-68 9⁴⁰A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY U.S.A BALTO		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 5-13-09 9. AGE (In years last birthday) 59	
13. FATHER'S NAME Glorioso Giuseppe		14. MOTHER'S MAIDEN NAME Serafina		11. BIRTHPLACE (State or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Dr. Charles Matteo Alberti ADDRESS 6720 Yataruba Drive # 7	
18. 426 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE PULMONARY EDEMA CHRONIC COR - PULMONALE			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 434.2 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/10 19 68 to 9/11 19 68 , that (I) (we) last saw the deceased alive on 8:15 A.M. 9/11/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE X MAKIPOUR		23B. DATE SIGNED 9/11/68		23C. PHYSICIAN'S NAME (Type) MAKIPOUR	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-68		24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Ellsworth Armacost		25D. ADDRESS 4600 Liberty Hgts.			

V. 14-15

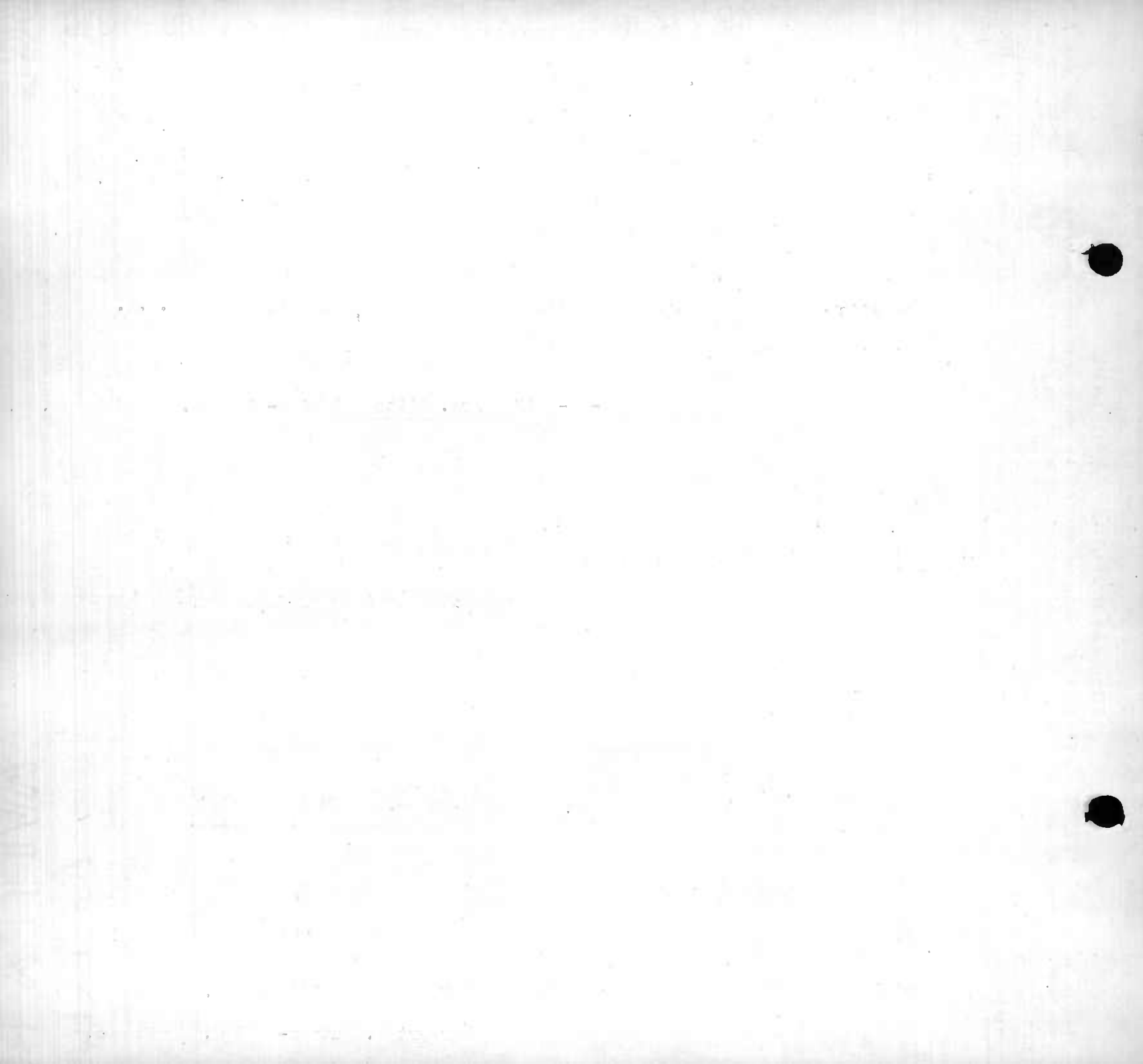
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9346 CERTIFICATE OF DEATH

REG. NO. **68- 9346**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HATTIE A. GREENE		2. DATE AND HOUR OF DEATH 9/10/68 12⁰⁰ A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Univ of Maryland Hosp		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md B. COUNTY Balt city	
CITY OR TOWN Balt city		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5 N Kossuth	
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/92		9. AGE (In years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Md., Granite	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Bell			
14. MOTHER'S MAIDEN NAME Emma Holland				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212-32-3017		17. INFORMANT Mrs. Alice Giddins- 1420 N. Rosedale St.			
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. AS CVD (B) Metas - CA origin? Cholelithiasis (C) Cholelithiasis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH deep year	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.11					
19A. DATE OF OPERATION 9/7/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholelithiasis, emphysema		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/4/68 to 9/10/68 , that (I) (we) last saw the deceased alive on 9/10/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE N. C. Bosch MD				23B. DATE SIGNED 9/10/68	
23C. PHYSICIAN'S NAME (Type) N. C. Bosch		23D. ADDRESS Univ of Md Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/68		24C. NAME of CEMETERY or CREMATORY Western Star Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave.			



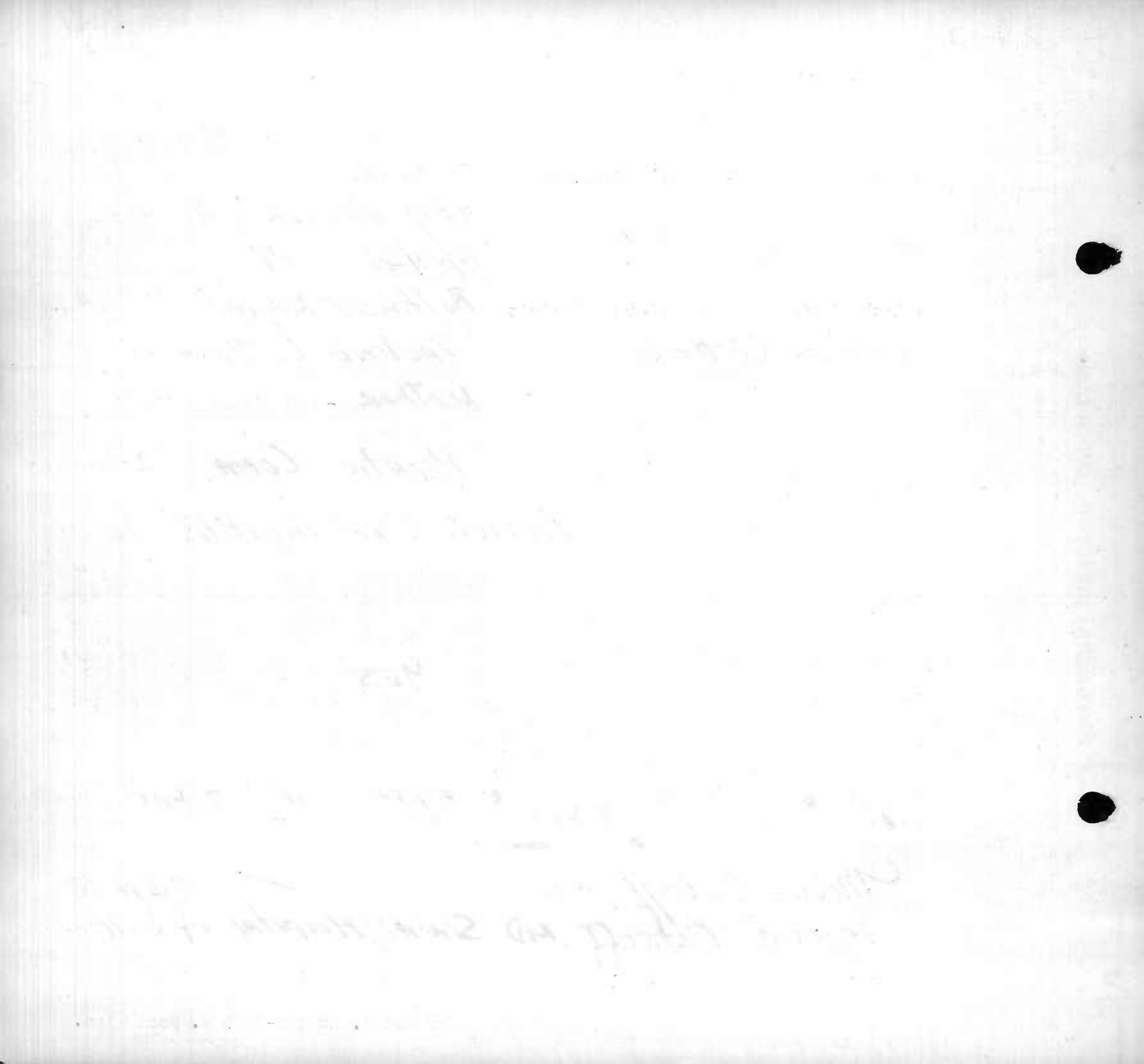
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9347 CERTIFICATE OF DEATH

REG. NO. 68- 9347

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Betty S. Jones</i>		2. DATE AND HOUR OF DEATH <i>7 Sept 1968 3:19 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>422 Palmer Avenue</i>					
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/28/38</i>	9. AGE (in years last birthday) <i>29</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stock Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Western Electric</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>CHARLES COTTMAN</i>		14. MOTHER'S MAIDEN NAME <i>PAULINE COTTMAN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MOTHER</i> ADDRESS <i>-2037 Division Street</i>	
18. <i>070X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hepatic Coma</i> (B) <i>Probable Viral Hepatitis</i> (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 weeks</i> <i>7 weeks</i>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>092X II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>6 August</i> 19 <i>68</i> to <i>7 Sept</i> 19 <i>68</i> , that (we) last saw the deceased alive on <i>7 Sept</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Morris Ostroff, MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7 Sept 68</i>	
23C. PHYSICIAN'S NAME (Type) <i>MORRIS OSTROFF, MD</i>		23D. ADDRESS <i>SINAI Hospital of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/12/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Herbert E. Nutter</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Herbert E. Nutter-3035 W. North Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9348 CERTIFICATE OF DEATH

REG. NO.

68- 9348

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary L. Jaymont

2. DATE AND HOUR OF DEATH

Sept. 12, 1968.

5:45 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3600 Parkside Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3600 Parkside Drive

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Feb. 2, 1884

9. AGE (In years
lost birthday)

84

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Jerome Pazarowski

14. MOTHER'S MAIDEN NAME

Mary

?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-26-6936

17. INFORMANT

Mrs. C. H. Mackinson

ADDRESS

(Same)

18. 15-7-9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 mos.

17 yrs

MEDICAL CERTIFICATION

15-7-X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1956 to 9/12/68
that (I) (we) last saw the deceased alive on 9/10/68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Walter E. Karfigin MD

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

9/13/68

23D. ADDRESS

1331 HARFORD ST.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/14/68

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1968

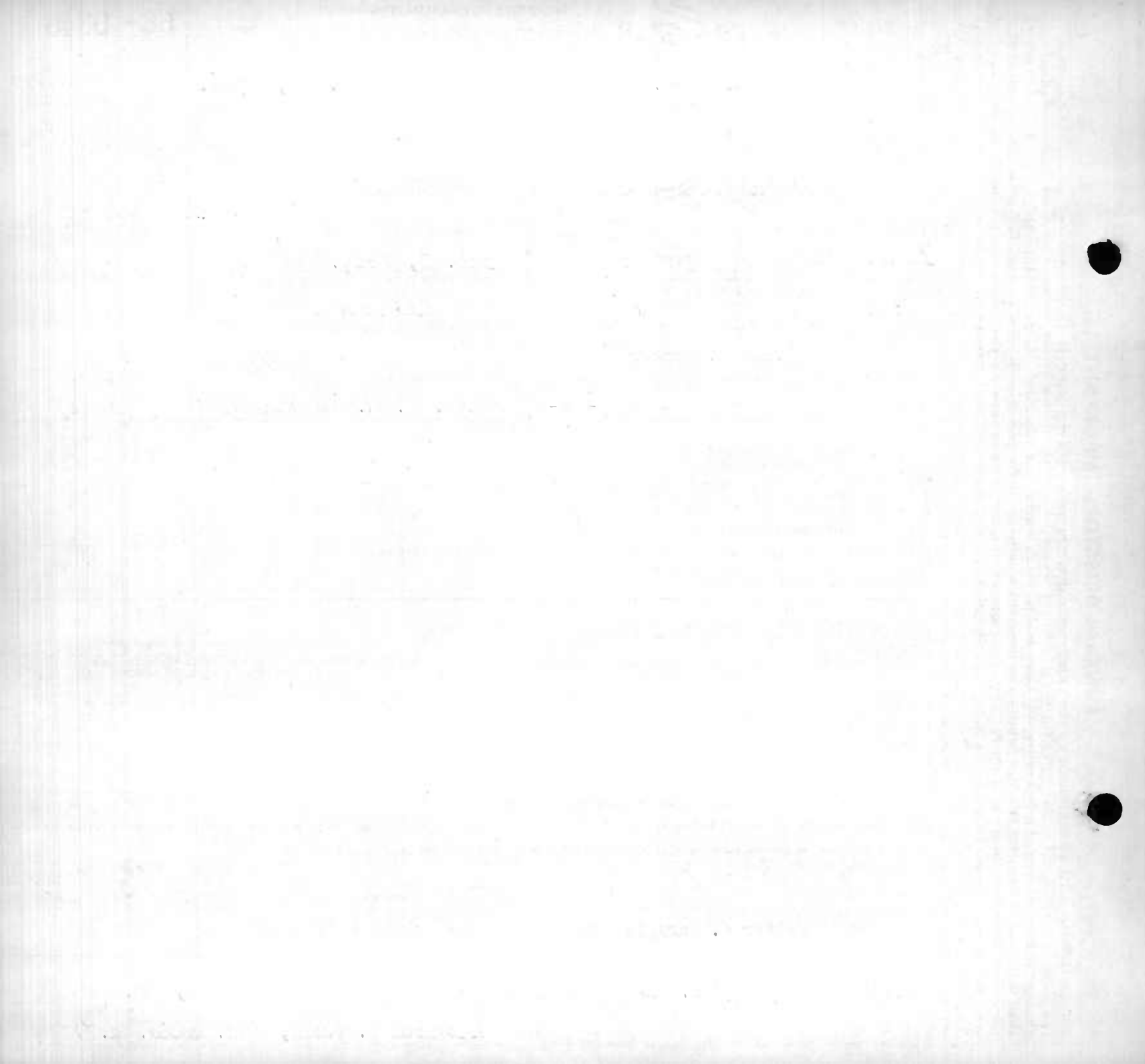
25B. NAME OF REGISTRAR

Robert E. Fabry

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS



NOT MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

5-5-36
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.
Not a Medical Examiner's Case per Dr. Springle

BIRTH NO. 68-17199		68- 9349		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 9349	
1. NAME OF DECEASED (Type or Print) Michael Joseph Schneider				2. DATE AND HOUR OF DEATH 9/10/68 955 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 626 EAST 31ST STREET			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NM	8. DATE OF BIRTH 9/9/68	9. AGE (In years last birthday) 1 DAY	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELMER SCHNEIDER				14. MOTHER'S MAIDEN NAME FAYE MCGEE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Elmer Schneider		ADDRESS (Same)	
18. 747.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 754.7 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE KNOWN.				CAUSE OF DEATH (A) CARDIAC ARRHYTHMIA DUE TO (B) MYOCARDIAL ISCHEMIA DUE TO (C) SEVERE PULMONARY INFUND. STENOSIS 1 DAY INTERVAL BETWEEN ONSET AND DEATH 30 min.			
19A. DATE OF OPERATION 9/10/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PULMONARY STENOSIS		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At [] At Work []		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/10/68 9:10 PM to 9/10/68 9:55 PM that (I) (we) last saw the deceased alive on 9/10 19 9:55 PM and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gordon F. Murray M.D.				23B. DATE SIGNED 9/10/68			
23C. PHYSICIAN'S NAME (Type) GORDON F. MURRAY M.D.				23D. ADDRESS Johns Hopkins Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/68		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or County) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS			

1001 10/10 11/11 12/12 13/13

Charles H. H. H.
H. H. H. H.
H. H. H. H.
H. H. H. H.

1001 10/10

1001 10/10

1001 10/10

1001 10/10

1001 10/10

1001 10/10

1001 10/10
1001 10/10
1001 10/10

1001 10/10
1001 10/10
1001 10/10

FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9350

BIRTH NO.		1. NAME OF DECEASED (Type or Print) IRRENE B. TOLSON		2. DATE AND HOUR OF DEATH SEPT. 12, 1968 12:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital 49			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3611 Mary Ave.		21206
5. SEX Female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-00	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Wilhelm		14. MOTHER'S MAIDEN NAME Addie ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-10-7071A		17. INFORMANT Husband Albert W. Tolson ADDRESS same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 199.01 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized metastatic carcinoma			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized metastatic carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 4 years		
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 6, 1968 to September 12, 1968 , that (I) (we) last saw the deceased alive on September 12, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED Sept 12, 1968	
23C. PHYSICIAN'S NAME (Type) SHELDON GOLDGEIER, M.D.				23D. ADDRESS North Charles General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21211			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9351 CERTIFICATE OF DEATH

REG. NO. 68- 9351

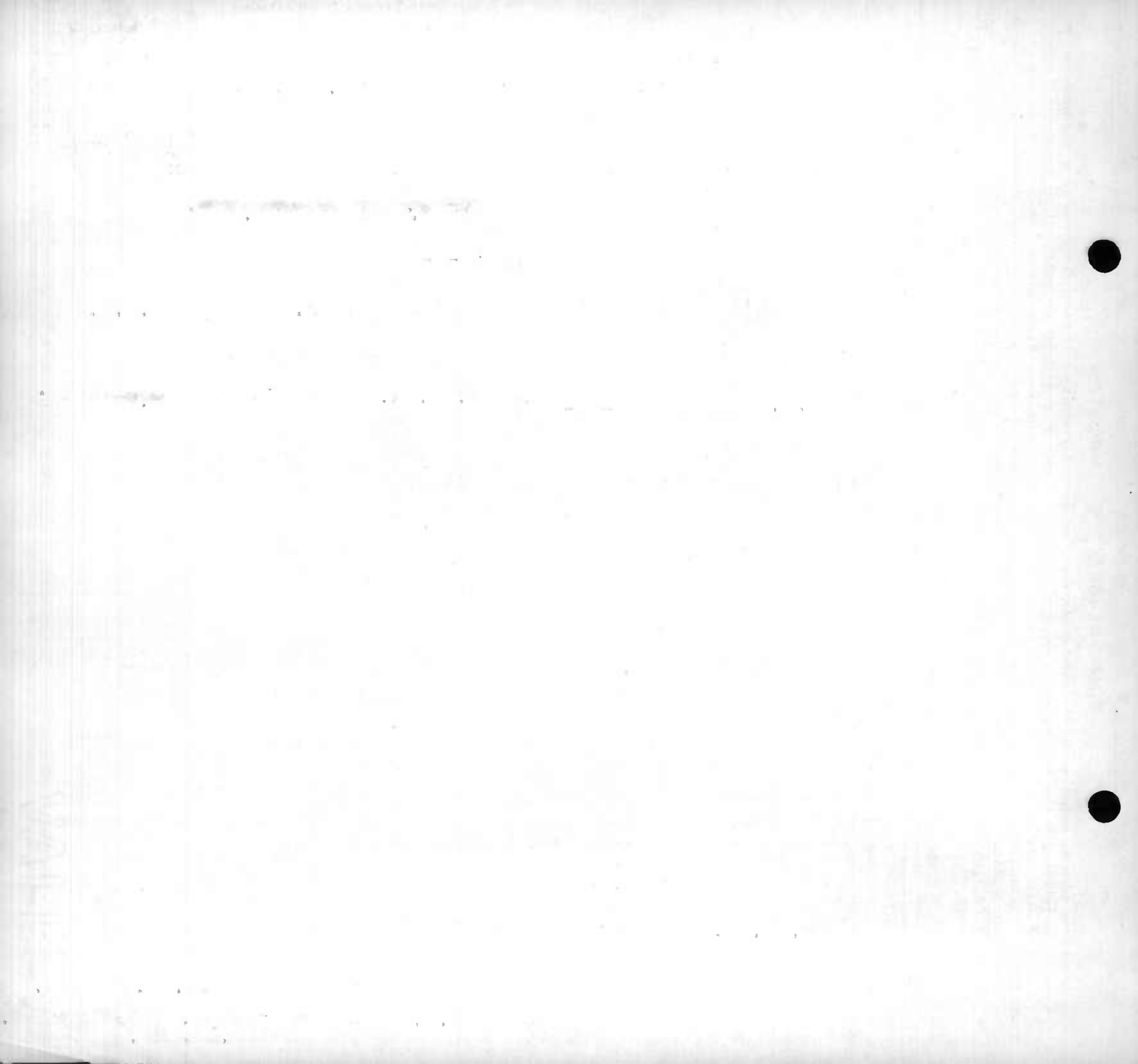
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Helen M. Smith</i>		2. DATE AND HOUR OF DEATH <i>12 Sept 1968 2:25 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>			C. CITY OR TOWN <i>Baltimore</i> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>2229 St. Paul St.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>05/01/85</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>MEDICAL</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Richard E. Smith</i>			14. MOTHER'S MAIDEN NAME <i>ANNIE Rogers</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-56-9097</i>	17. INFORMANT <i>MRS. W. L. HUDSON</i> ADDRESS <i>(Pt.) 110 WOODLAWN DRIVE CALIFORNIA Md. 20619</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Released in approval of Dr. Swoboda, Med. Myocardial Infarction</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i>		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>unknown</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Heart Failure & Uremia (BUN 97 on 9-12)</i>		
19A. DATE OF OPERATION <i>4-20-11</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		
20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 10</i> 19 <i>68</i> to <i>Sept. 12</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Sept. 12</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard C. Keech MD</i>			23B. DATE SIGNED <i>Sept. 12, 1968</i>		
23C. PHYSICIAN'S NAME (Type) <i>RICHARD C. KEECH MD</i>			23D. ADDRESS <i>827 Linden Ave. Balto. 21201</i>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>9/16/68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1968</i>		25B. NAME OF REGISTRAR <i>John E. Jenkins</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i>	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9352 CERTIFICATE OF DEATH

REG. NO. 68- 9352

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Maurice Falconer Rodgers		Sept. 11, 1968 6 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home		A. STATE Maryland		B. COUNTY Baltimore	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 115 E. Melrose Ave.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-5-1888	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Real Estate		10B. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Rodgers		14. MOTHER'S MAIDEN NAME Frances Falconer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 214-01-8878		17. INFORMANT Mrs. K. R. McLaughlin 845 W. University Pkwy.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: URINARY TRACT INFECTION (B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS of CORONARY (C) GENERAL ARTERIOSCLEROSIS No N		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 430.0 II		21. DATE OF OPERATION None		22. CONDITION FOR WHICH OPERATION WAS PERFORMED None	
23. DATE OF OPERATION None		24. AUTOPSY? (Yes or No) None		25. IF YES, WERE FINDINGS CONSIDERED IN IDENTIFYING CAUSES OF DEATH? None	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
29. TIME OF INJURY (Month) (Day) (Year) (Hour) None		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR? None	
32. I certify that (I) (this hospital) attended the deceased from 1955 to Sept 11 1968, that (I) (we) last saw the deceased alive on Sept 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
33. SIGNATURE As. Chalfant		34. DATE SIGNED Sept 11 '68		35. PHYSICIAN'S NAME (Type) Dr. A. S. Chalfant	
36. PHYSICIAN'S NAME (Type) Dr. A. S. Chalfant		37. ADDRESS 6210 York Road		38. DATE SIGNED Sept 11 '68	
39. BURIAL CREMATION, REMOVAL (Specify) Burial		40. DATE 9/14/68		41. NAME of CEMETERY or CREMATORY Lorraine Park	
42. LOCATION (City, town, or county) Woodlawn, Balto. Co.,		43. (State) Md.		44. DATE REC'D BY HEALTH DEPT. SEP 13 1968	
45. NAME OF REGISTRAR R. E. Jenkins		46. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		47. ADDRESS 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

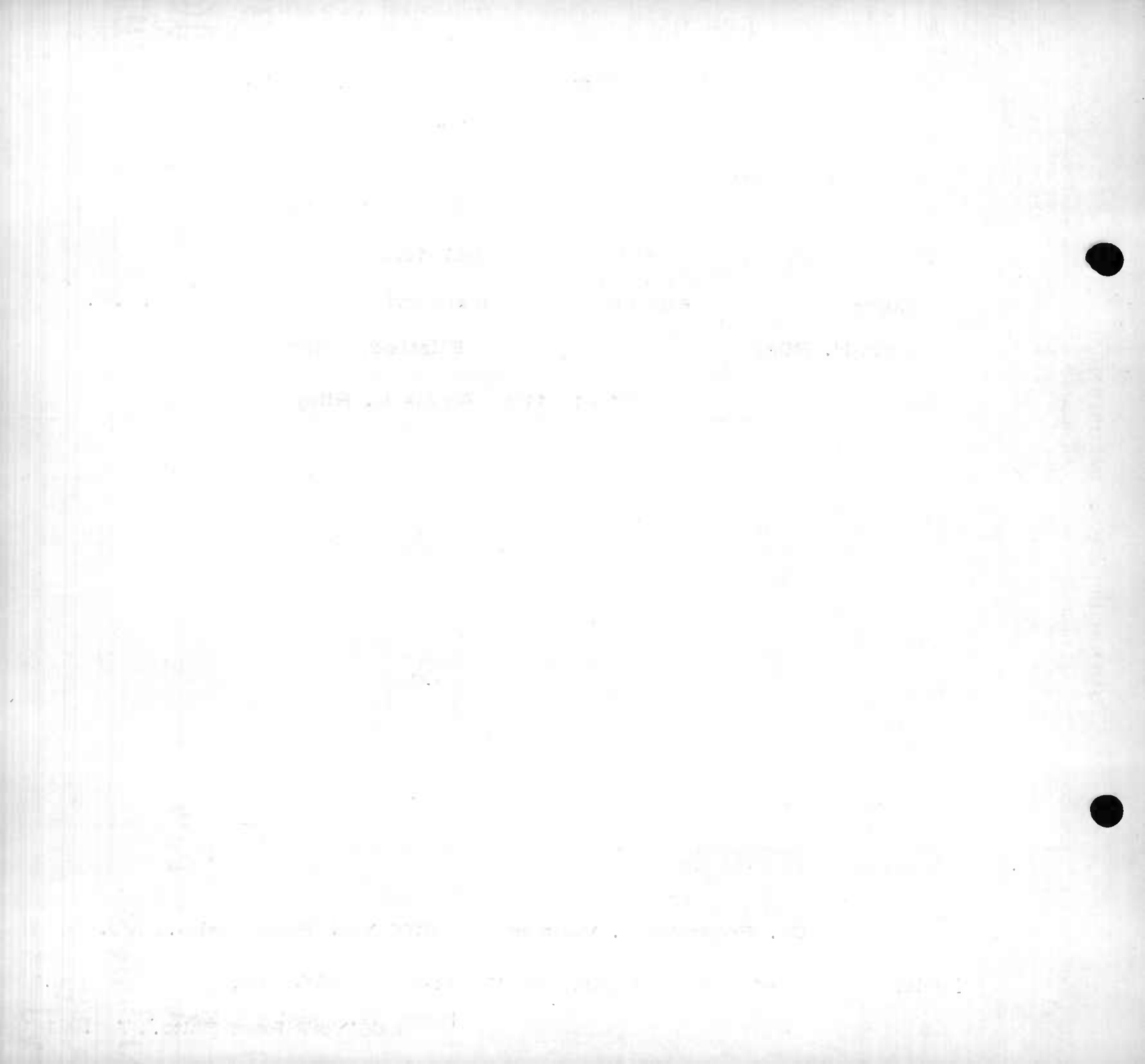
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9353 CERTIFICATE OF DEATH

REG. NO.

68- 9353

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ann Oakley Kuehn		Sept. 12, 1968 5:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 5500 Ready Avenue				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5500 Ready Avenue	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-27-1890	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John H. Riley				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Elizabeth Nolan					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-16-1168		17. INFORMANT Angela L. Riley	
				ADDRESS Same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 398X I				1/2 hr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				60+ yr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 416X II				15+ yr.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Apr 9 1954 to Sept 12 1968, that (I) (we) last saw the deceased alive on Sept 12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer				23B. DATE SIGNED 9-13-68	
23C. PHYSICIAN'S NAME (Type) Dr. Frederick J. Vollmer				23D. ADDRESS 6100 York Road Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-68		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9354

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LOLA

W.

Gourley

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 10, 1968

10:10 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 10, 1968

10:10 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

female

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Oct. 7, 1888

10. AGE (In years
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

116 W. University Parkway

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Woodward

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired-Clerk Md. Casualty Ins. Co.

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Isabelle

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

212-10-3624

18. INFORMANT

ADDRESS

21201

Thomas J. Grogan, Jr. 929 N. Howard St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/10/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/12/68

24C. NAME of CEMETERY or CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

H.W. Jenkins & Sons Co. 4905 York Rd.

Balto. 12, Md.

WALTON

Percey G. G.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9355 CERTIFICATE OF DEATH

REG. NO.

68- 9355

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Donald Hamilton

2. DATE AND HOUR OF DEATH

9-11-68

2:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3406 O Kenshaw Place

5. SEX

male

6. RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-4-89

9. AGE (In years
last birthday)

79

If Under 1 Yr.

Months; Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Florist Flowers

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Hamilton

14. MOTHER'S MAIDEN NAME

Cora Whitmarsh

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Unknown No

16. SOCIAL
SECURITY NO.

218-32-1847A

17. INFORMANT

Mrs. Marjorie B. Hamilton (Sister)

ADDRESS

18.

157.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Infection & anemia

Weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Metastatic carcinoma of

DUE TO, OR AS A CONSEQUENCE OF:

stomach

Months

(C)

MEDICAL CERTIFICATION

15-IX II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-20 1968 to 9-11 1968,
that (I) (we) last saw the deceased alive on 9-11 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

RK Gundry MD

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

9-11-68

23C. PHYSICIAN'S
NAME (Type)

RK GUNDRY

23D. ADDRESS

2 W University Pkwy 21218

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/13/68

24C. NAME OF CEMETERY or CREMATORY

Greenmount

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Road
Balto., Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9356 CERTIFICATE OF DEATH

REG. NO. 68- 9356

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES H. DORSEY		2. DATE AND HOUR OF DEATH SEPT. 12, 1968 7:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE VIRGINIA B. COUNTY V-43	
		C. CITY OR TOWN ROANOKE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 1118 WASENA AVENUE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 21, 1900	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		10B. KIND OF BUSINESS OR INDUSTRY LUMBER		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WM. C. DORSEY				14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-0528		17. INFORMANT (CHAR) MRS. JOSEPH PURCELL	
				ADDRESS ROUTE 3, ANNAPOLIS, MD	
18. 4 10 19 I		CAUSE OF DEATH ACUTE MYO CARDIAL INFARCTION 5-6 hrs.			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 11 1968 to Sept 12 1968 , that (I) (we) last saw the deceased alive on Sept 12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tony D. Lehua MD				23B. DATE SIGNED Sept. 12/68	
23C. PHYSICIAN'S NAME (Type) HONG TI CHUA, MD				23D. ADDRESS Union Memorial Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/68		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968			
25B. NAME OF REGISTRAR Charles E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

Good Memorial Hospital

68- 9357 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9357

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JAMES F. CANNON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 7, 1968 2:17 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL (DOA) (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 7, 1968 2:17 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE D.C. B. COUNTY V-48			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 78 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN Washington	
11. BIRTHPLACE (State or foreign country)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 14 Delano Lane	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. CAUSE OF DEATH 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 8, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-11-68	24C. NAME of CEMETERY or CREMATORY Baltimore Natl. Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1968	25B. NAME OF REGISTRAR Robert E. [Signature]	25C. FUNERAL DIRECTOR ADDRESS Wilhelm Funeral Home 4308 Suitland Rd. S. E.	

4

1. The first of these

is the fact that

the second of these

is the fact that

the third of these

is the fact that

is the fact that

the fourth of these

is the fact that

the fifth of these

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9358 CERTIFICATE OF DEATH

REG. NO. 68- 9358

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPH WACLAWSKI, SR.		September 10, 1968 12:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
<div style="text-align: center;"> CERTIFICATE AMENDED <small>9-20-68</small> </div>		A. STATE MD.			
FULL NAME OF HOSPITAL OR INSTITUTION 603 S. Eaton St. Baltimore, 21224, Md.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 603 S. Eaton St. # 21224.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 29, 1889	79	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Crown, Cork & Seal Co.		Hickory, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Wacławski			Agnes Mucha		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT.	
No		212-01-5246		Franciszka Kamila Wacławski Kamila E. Wacławski	
				ADDRESS 603 S. Eaton St. Same.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		Crown Thrombosis			
ANTECEDENT CAUSES		(B) Anterior Cerebral V. Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Hypertension			
420.1 II		Sensitivity			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from September 19 67 to September 10 1968, that (I) (we) last saw the deceased alive on April 8 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Jason H. Gaskel M.D.		Sept 12, 1968			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JASON H. GASKEL		637 S. Conkling St., Balto., 21224, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-13-68		Sacred Heart Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				7401 German Hill Rd. Ba., Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 13 1968		Robert E. Farkas		Charles S. Guler	
				ADDRESS 901 S. Conkling St. Balto., 21224, Md.	

Handwritten notes, possibly a list or index, written vertically in cursive script. The text is difficult to decipher but appears to include words like "The", "of", and "the".

Handwritten notes, possibly a list or index, written vertically in cursive script. The text is difficult to decipher but appears to include words like "The", "of", and "the".

Handwritten notes, possibly a list or index, written vertically in cursive script. The text is difficult to decipher but appears to include words like "The", "of", and "the".

Handwritten notes, possibly a list or index, written vertically in cursive script. The text is difficult to decipher but appears to include words like "The", "of", and "the".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-9359 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-9359
BIRTH NO. <u>MURPHY MRS DIAI</u>		1. NAME OF DECEASED (Type or Print) <u>MURPHY, MRS. MARY ELIZABETH</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u> <u>35</u>		2. DATE AND HOUR OF DEATH <u>9-11-1968</u> <u>4:15 A.M.</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>9303 FOSTER AVE, APT 2nd H. (24)</u>		5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-88</u>		9. AGE (In years last birthday) <u>80</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William King</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS GALENHEIMER</u> <u>Grand daughter</u> Address <u>Phone - 255 9556</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac arrest due to myocardial infarction, A.S.H.D.,</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Diabetes mellitus.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>e.e.f.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>260X II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9.10.1968</u> to <u>9.11.1968</u> , that (I) (we) last saw the deceased alive on <u>9.11.1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mesbahud Dowla</u>		23B. DATE SIGNED <u>9.11.1968</u>		23C. PHYSICIAN'S NAME (Type) <u>MESBAH UD-DOWLA</u>	
23D. ADDRESS <u>CHURCH HOME AND HOSPITAL.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-14-68</u>		24C. NAME of CEMETERY or CREMATORY <u>SACRED HEART CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD. BALCO, MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Charles S. ...</u>	
25D. ADDRESS <u>901 S. CONKLING ST. BALTO, 11224, MD.</u>					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9361

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOROTHY MAE O'CONNOR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 10, 1968 10:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 10, 1968 10:49 A.M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb. 10, 1919		10. AGE (In years last birthday) 48	
11. BIRTHPLACE (State or foreign country) Porchester, New York		12. CITIZEN OF WHAT COUNTRY? Al Blackman	
13. FATHER'S NAME Al Blackman		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Own Home		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Shawn P. O'Connor	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Whiplash Injury with Transection of Medulla Oblongata ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 8 12 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). E 8 7 6 4 II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) St. Rte. 7, 3/10 mi. N. of Ridge Rd.	
22D. TIME OF INJURY (APPROX.) 9/10/68 10:10 A. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Passenger in auto which was struck by a tractor trailer		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/10/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9-16-1968	
24C. NAME OF CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	

Handwritten signature or mark, possibly reading "Alfred" or similar, written in dark ink.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9362	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ISAAC C. WATKINS			2. DATE AND HOUR OF DEATH 9/11/68 1:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hosp			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 431 E. Lafayette Avenue		
5. SEX M	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/87		9. AGE (In years lost birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Isaac R. Watkins			14. MOTHER'S MAIDEN NAME Amelia J. Anderson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-5869		17. INFORMANT ADDRESS Blanche Davis - 431 E. Lafayette Ave.	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: M1 (B) Chronic pyelonephritis DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH +1 hour +1 month +10 years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-24 1968 to 9/11 1968 , that (I) (we) last saw the deceased alive on 9/11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barbedo				23B. DATE SIGNED 9/11/68	
23C. PHYSICIAN'S NAME (Type) ALBERTO S. BARBEDO				23D. ADDRESS MERCY HOSP. - BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.	

18 18/1/51 7

19

1950

1950

19

19

1950

1950

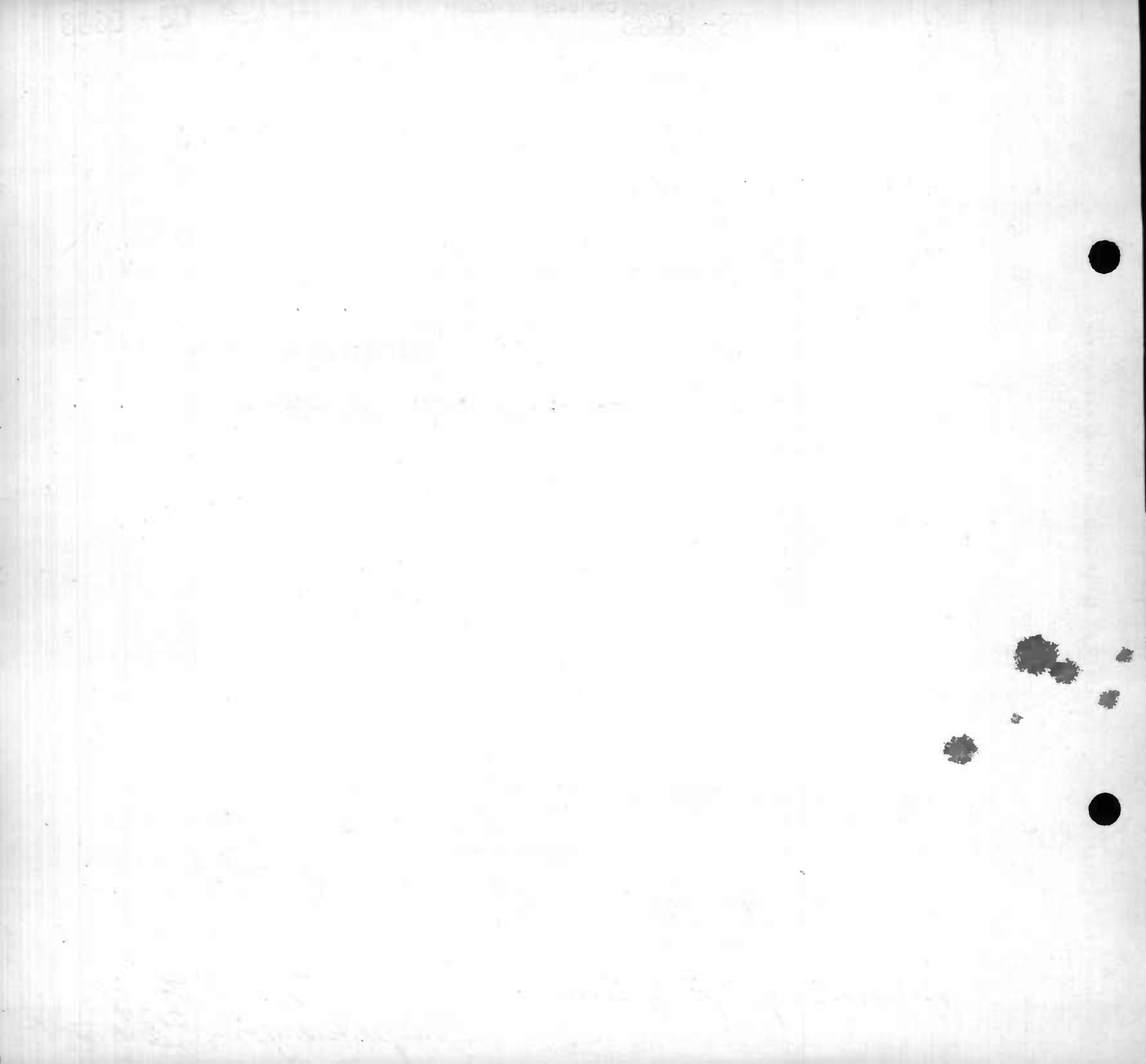
1950

1950

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased ALL was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-9363
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Hall, Thomas H.		9/10/68 3:00 p.m.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
The Johns Hopkins Hospital		West Virginia V-45		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Ansted		YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1-16-96	72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Miner		Coal Mining		Franklin Co. Va.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Flem Hall		Ruth Bartrum Mary Massey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
yes WW1		335-09-4062		Ruth Bartrum Ruth Bartrum, Ansted W. Va.
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
493.0 II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2		yes	no	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		
22. I certify that (I) (this hospital) attended the deceased from 9/8 1968 to 9/10 1968, that (I) (we) last saw the deceased alive on 9/10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Carole Dorsch		9/10/68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Carole Dorsch		Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Removal Sept 11/68		Bethelton	Victory W. Va.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS	
SEP 16 1968	Robert E. Jenkins	Philip Herwig	2020 Williams St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

68- 9364 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9364

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN DAFIN SR.		9/9/68 8 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND	
				C. CITY OR TOWN Baltimore	
				E. STREET AND NUMBER 522 Tolna St. # 21224	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8-29-97	
Retired		Beth. Steel Co.		9. AGE (In years last birthday) 71	
13. FATHER'S NAME JOHN DAFIN		14. MOTHER'S MAIDEN NAME MARY POPA		11. BIRTHPLACE (State or foreign country) Hungary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-1356		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT Theresa Dafin		ADDRESS Same.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic bronchogenic ca (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Emphysema (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8-10 mos	
162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input checked="" type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/3/1968 to 9/9/1968, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Edward Block MD				23B. DATE SIGNED 9/9/68	
23C. PHYSICIAN'S NAME (Type) Edward Block MD				23D. ADDRESS Johns Hopkins Hospital Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-68		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION 7401 German Hill Rd., Ba. Co., Md.		24E. NAME of REGISTRAR Charles S. Jester		24F. FUNERAL DIRECTOR 6224 Eastern Ave. Balto., 21224, Md.	

Miss Alice Brewster

Emphatic

Yes

No

9/2/00

Edward Black

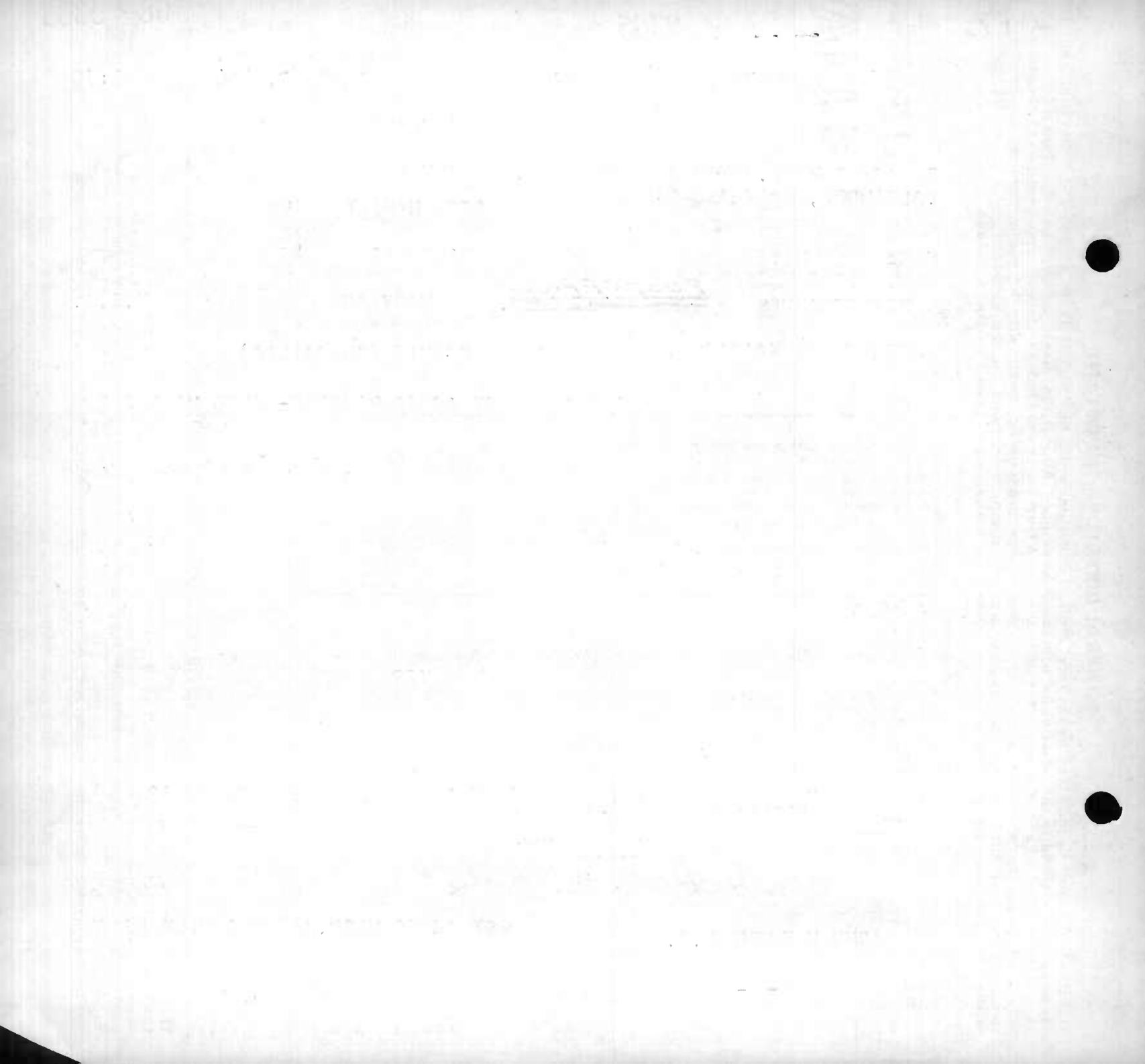
Edward Black

John Hopkins

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 9365</u>
BIRTH NO. <u>68- 9365</u>				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) PECHULIS, MARY FRANCES		2. DATE AND HOUR OF DEATH SEPT 13, 1968 3:50 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSP. CATON & WILKENS AVE BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2509 HAMILTON AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03 09 23 45	9. AGE (In years last birthday) 45 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENOGRAPHER		10B. KIND OF BUSINESS OR INDUSTRY POST OFFICE STATE ROUTES COMM.		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH MATUKAITIS		
14. MOTHER'S MAIDEN NAME SOPHIE (CUNGAILIA)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 215162806		17. INFORMANT ADDRESS ST AGNES RECORDS-BALTO MD 21229		
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Breast Carcinoma 1 year		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. 170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPT 3 19 68 to SEPT 13 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPT 13 19 68 and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.				
23A. SIGNATURE John H. Tuohy, M.D.		23B. DATE SIGNED 9/13/68		23C. PHYSICIAN'S NAME (Type) JOHN H TUOHY M.D.
23D. ADDRESS ST AGNES HOSP. CATON & WILKENS AVE		24. LOCATION (City, town, or county) (State) Baltimore, Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-17-68	24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cem	24D. ADDRESS Thomas J Kenny Inc Balto Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968	25B. NAME OF REGISTRAR Robert E. Farber	25C. FUNERAL DIRECTOR Thomas J Kenny Inc Balto Md		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

68- 9366 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 1387 9366

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CAMPER ERNEST		2. DATE AND HOUR OF DEATH 9-10-68 5:40 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION BOLTON HILL NURSING AND CONVALESCENT CENTER		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2907 HERO RD			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/89	9. AGE (In years last birthday) 99
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Camper		14. MOTHER'S MAIDEN NAME Celeste G.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 224-28-9292		17. INFORMANT ADMISSION RECORD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.3 I CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: coronary heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		(B) arteriosclerosis generalized DUE TO, OR AS A CONSEQUENCE OF: years			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 9/10/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/6 1968 to 9/10 1968 , that (I) (we) last saw the deceased alive on 9/10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE AL H. MACHAT MD		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE, SIGNED 9/10/68	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHAT MD		23D. ADDRESS 2 E. READ ST BALTIMORE 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/12/68	24C. NAME OF CEMETERY or CREMATORY Louisa Park		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968	25B. NAME OF REGISTRAR Robert E. Johnson	25C. FUNERAL DIRECTOR Wm. J. Tichauer-Son		ADDRESS Balto., Md.	

Retired
William C. Rogers
Celeste G.
— No

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

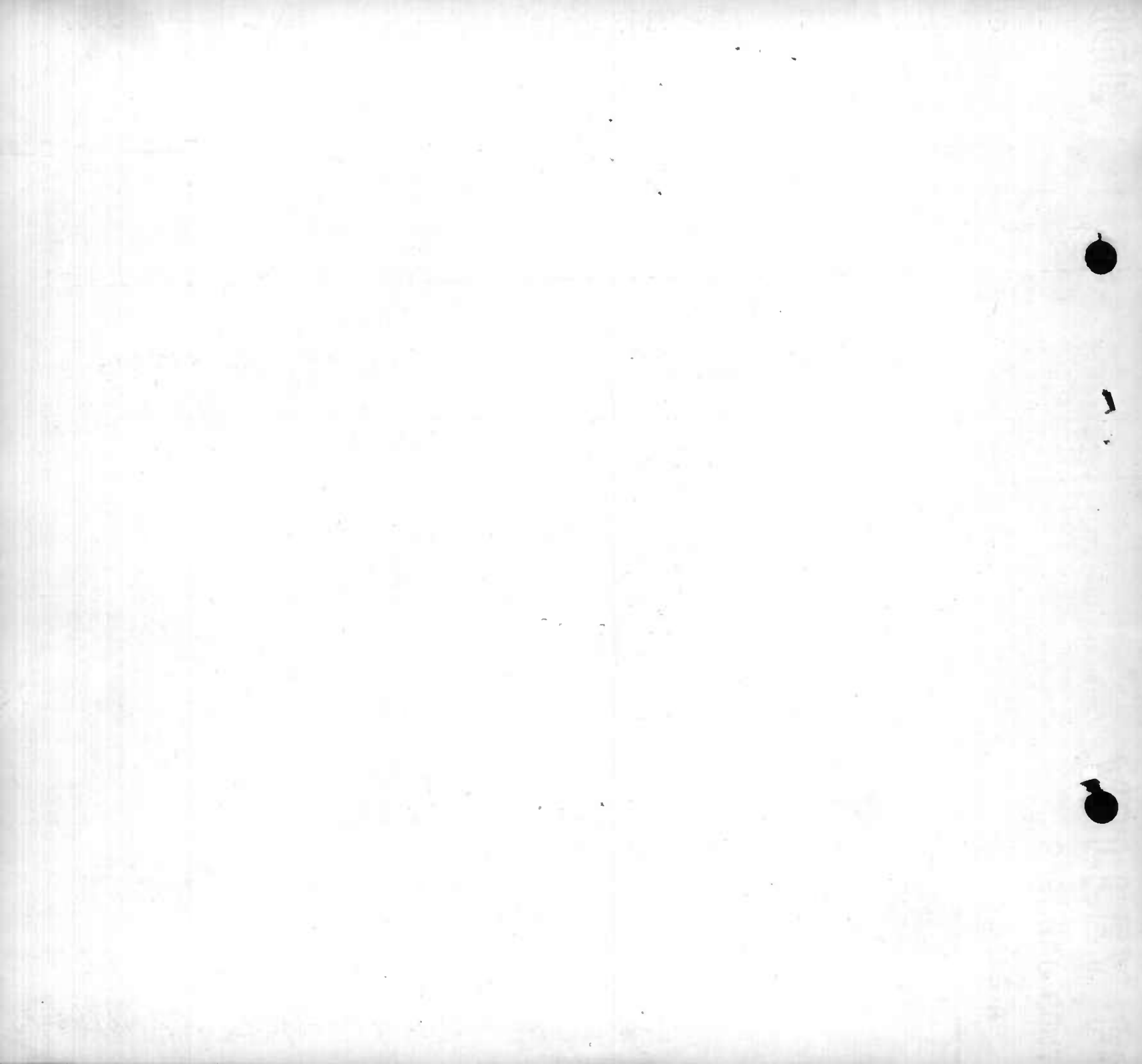
68- 9367

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 9367

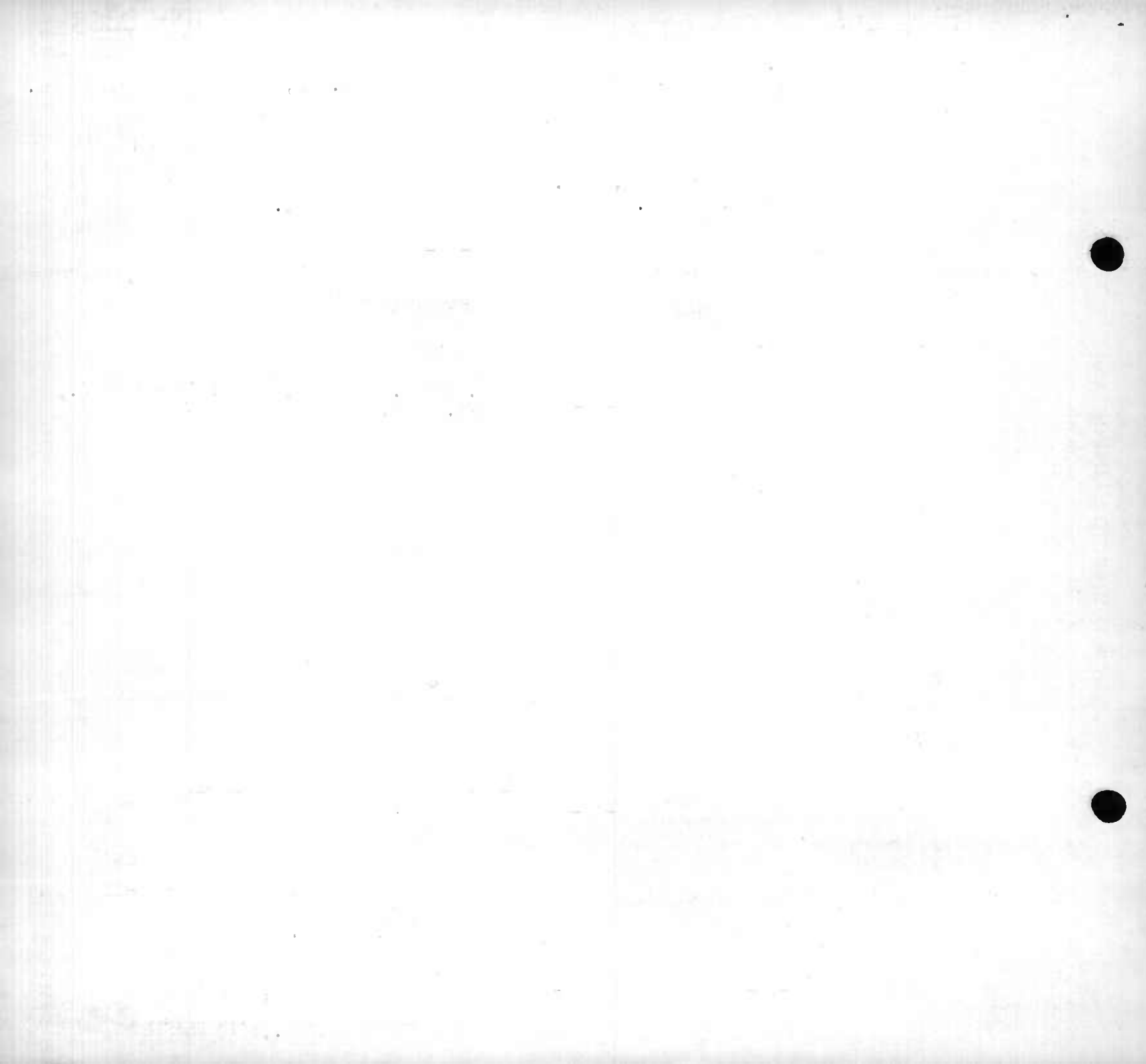
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDWARD DOLAN		2. DATE AND HOUR OF DEATH 9:55 AM. 9/9/68 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL 38		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. B. COUNTY Rosewood	
C. CITY OR TOWN Balt. Md.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 5246 Linden Heights Ave. 27-18	
5. SEX M	6. RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/97	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Mentally Retarded		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Dolan		14. MOTHER'S MAIDEN NAME Hannah Cropper	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. E 887X1		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or complication which caused death.) Possible Pulmonary Emboli		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.		IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Thrombophlebitis @ leg		4 days.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z) (AA) (AB) (AC) (AD) (AE) (AF) (AG) (AH) (AI) (AJ) (AK) (AL) (AM) (AN) (AO) (AP) (AQ) (AR) (AS) (AT) (AU) (AV) (AW) (AX) (AY) (AZ) (BA) (BB) (BC) (BD) (BE) (BF) (BG) (BH) (BI) (BJ) (BK) (BL) (BM) (BN) (BO) (BP) (BQ) (BR) (BS) (BT) (BU) (BV) (BW) (BX) (BY) (BZ) (CA) (CB) (CC) (CD) (CE) (CF) (CG) (CH) (CI) (CJ) (CK) (CL) (CM) (CN) (CO) (CP) (CQ) (CR) (CS) (CT) (CU) (CV) (CW) (CX) (CY) (CZ) (DA) (DB) (DC) (DD) (DE) (DF) (DG) (DH) (DI) (DJ) (DK) (DL) (DM) (DN) (DO) (DP) (DQ) (DR) (DS) (DT) (DU) (DV) (DW) (DX) (DY) (DZ) (EA) (EB) (EC) (ED) (EE) (EF) (EG) (EH) (EI) (EJ) (EK) (EL) (EM) (EN) (EO) (EP) (EQ) (ER) (ES) (ET) (EU) (EV) (EW) (EX) (EY) (EZ) (FA) (FB) (FC) (FD) (FE) (FF) (FG) (FH) (FI) (FJ) (FK) (FL) (FM) (FN) (FO) (FP) (FQ) (FR) (FS) (FT) (FU) (FV) (FW) (FX) (FY) (FZ) (GA) (GB) (GC) (GD) (GE) (GF) (GG) (GH) (GI) (GJ) (GK) (GL) (GM) (GN) (GO) (GP) (GQ) (GR) (GS) (GT) (GU) (GV) (GW) (GX) (GY) (GZ) (HA) (HB) (HC) (HD) (HE) (HF) (HG) (HH) (HI) (HJ) (HK) (HL) (HM) (HN) (HO) (HP) (HQ) (HR) (HS) (HT) (HU) (HV) (HW) (HX) (HY) (HZ) (IA) (IB) (IC) (ID) (IE) (IF) (IG) (IH) (II) (IJ) (IK) (IL) (IM) (IN) (IO) (IP) (IQ) (IR) (IS) (IT) (IU) (IV) (IW) (IX) (IY) (IZ) (JA) (JB) (JC) (JD) (JE) (JF) (JG) (JH) (JI) (JJ) (JK) (JL) (JM) (JN) (JO) (JP) (JQ) (JR) (JS) (JT) (JU) (JV) (JW) (JX) (JY) (JZ) (KA) (KB) (KC) (KD) (KE) (KF) (KG) (KH) (KI) (KJ) (KK) (KL) (KM) (KN) (KO) (KP) (KQ) (KR) (KS) (KT) (KU) (KV) (KW) (KX) (KY) (KZ) (LA) (LB) (LC) (LD) (LE) (LF) (LG) (LH) (LI) (LJ) (LK) (LM) (LN) (LO) (LP) (LQ) (LR) (LS) (LT) (LU) (LV) (LW) (LX) (LY) (LZ) (MA) (MB) (MC) (MD) (ME) (MF) (MG) (MH) (MI) (MJ) (MK) (ML) (MN) (MO) (MP) (MQ) (MR) (MS) (MT) (MU) (MV) (MW) (MX) (MY) (MZ) (NA) (NB) (NC) (ND) (NE) (NF) (NG) (NH) (NI) (NJ) (NK) (NL) (NM) (NO) (NP) (NQ) (NR) (NS) (NT) (NU) (NV) (NW) (NX) (NY) (NZ) (OA) (OB) (OC) (OD) (OE) (OF) (OG) (OH) (OI) (OJ) (OK) (OL) (OM) (ON) (OO) (OP) (OQ) (OR) (OS) (OT) (OU) (OV) (OW) (OX) (OY) (OZ) (PA) (PB) (PC) (PD) (PE) (PF) (PG) (PH) (PI) (PJ) (PK) (PL) (PM) (PN) (PO) (PP) (PQ) (PR) (PS) (PT) (PU) (PV) (PW) (PX) (PY) (PZ) (QA) (QB) (QC) (QD) (QE) (QF) (QG) (QH) (QI) (QJ) (QK) (QL) (QM) (QN) (QO) (QP) (QQ) (QR) (QS) (QT) (QU) (QV) (QW) (QX) (QY) (QZ) (RA) (RB) (RC) (RD) (RE) (RF) (RG) (RH) (RI) (RJ) (RK) (RL) (RM) (RN) (RO) (RP) (RQ) (RR) (RS) (RT) (RU) (RV) (RW) (RX) (RY) (RZ) (SA) (SB) (SC) (SD) (SE) (SF) (SG) (SH) (SI) (SJ) (SK) (SL) (SM) (SN) (SO) (SP) (SQ) (SR) (SS) (ST) (SU) (SV) (SW) (SX) (SY) (SZ) (TA) (TB) (TC) (TD) (TE) (TF) (TG) (TH) (TI) (TJ) (TK) (TL) (TM) (TN) (TO) (TP) (TQ) (TR) (TS) (TT) (TU) (TV) (TW) (TX) (TY) (TZ) (UA) (UB) (UC) (UD) (UE) (UF) (UG) (UH) (UI) (UJ) (UK) (UL) (UM) (UN) (UO) (UP) (UQ) (UR) (US) (UT) (UU) (UV) (UW) (UX) (UY) (UZ) (VA) (VB) (VC) (VD) (VE) (VF) (VG) (VH) (VI) (VJ) (VK) (VL) (VM) (VN) (VO) (VP) (VQ) (VR) (VS) (VT) (VU) (VV) (VW) (VX) (VY) (VZ) (WA) (WB) (WC) (WD) (WE) (WF) (WG) (WH) (WI) (WJ) (WK) (WL) (WM) (WN) (WO) (WP) (WQ) (WR) (WS) (WT) (WU) (WV) (WW) (WX) (WY) (WZ) (XA) (XB) (XC) (XD) (XE) (XF) (XG) (XH) (XI) (XJ) (XK) (XL) (XM) (XN) (XO) (XP) (XQ) (XR) (XS) (XT) (XU) (XV) (XW) (XX) (XY) (XZ) (YA) (YB) (YC) (YD) (YE) (YF) (YG) (YH) (YI) (YJ) (YK) (YL) (YM) (YN) (YO) (YP) (YQ) (YR) (YS) (YT) (YU) (YV) (YW) (YX) (YY) (YZ) (ZA) (ZB) (ZC) (ZD) (ZE) (ZF) (ZG) (ZH) (ZI) (ZJ) (ZK) (ZL) (ZM) (ZN) (ZO) (ZP) (ZQ) (ZR) (ZS) (ZT) (ZU) (ZV) (ZW) (ZX) (ZY) (ZZ)		19A. DATE OF OPERATION 8/26/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FX @ HIP	
20A. AUTOPSY? (Yes or No) ?		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. BIRTHPLACE (State or foreign country) B. lateral HIP PINNING 8/26/68	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) State Road		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rosewood St. Home 53-00	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 2 weeks prior to death		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fall	
22. I certify that (I) (this hospital) attended the deceased from Sept. 6, 1968 to Sept 9, 1968 , that (I) (we) last saw the deceased alive on Sept 9, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joel M. Cherry, M.D.				23B. DATE SIGNED 9/9/68	
23C. PHYSICIAN'S NAME (Type) Joel M. Cherry, M.D.				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/13/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Balt., Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Wm. J. Trchner	
25C. FUNERAL DIRECTOR Wm. J. Trchner		25D. ADDRESS From Balt., Md.		25E. DATE REC'D BY HEALTH DEPT.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

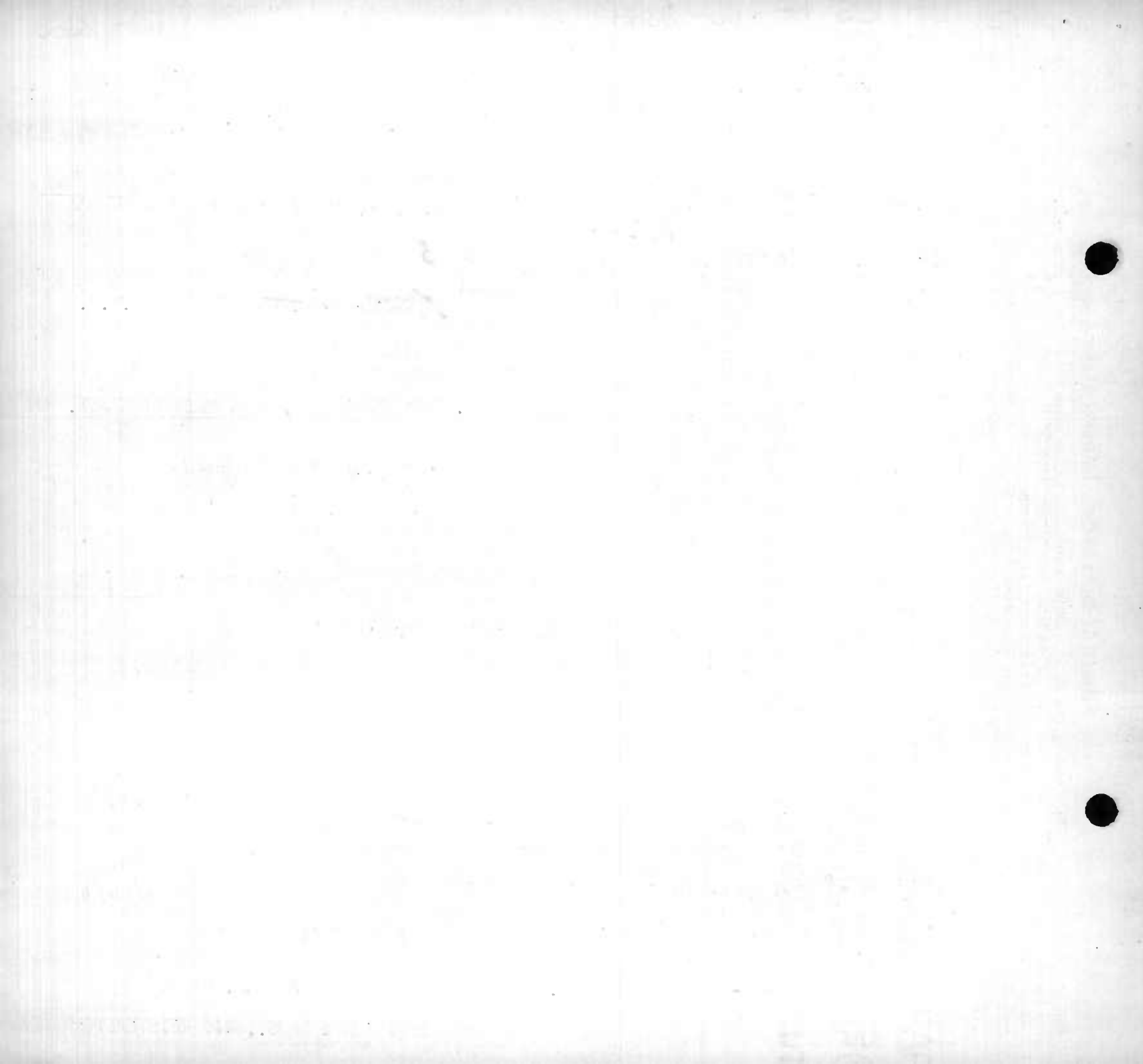
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9368
BIRTH NO. F-624		68- 9368 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) S. Mary Forschlager		2. DATE AND HOUR OF DEATH Sept. 12, 1968 8:25 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division St.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 13-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2601 Madison Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-96	9. AGE (In years lost birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEHOLD		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) POLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ABRAHAM FORSCHLAGER		
14. MOTHER'S MAIDEN NAME BLUMA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 218-34-1025		17. INFORMANT ADDRESS MRS. INA K. GINSBERG, TEMPLE GARDEN APTS., APT. 101A, 2601 MADISON AVENUE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II				
21A. DATE OF OPERATION 0	21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21C. AUTOPSY? (Yes or No) No	21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 9-12-68 to 9-12-68 that (I) (we) lost saw the deceased olive on 9-12-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE M. J. Kook		23B. DATE SIGNED 9-12-68		23C. PHYSICIAN'S NAME (Type) Min Ja Kook
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-68		24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH-BETH ISRAEL
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9369
68- 9369		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GREENBERG, ESTHER		2. DATE AND HOUR OF DEATH Sept. 12, 1968 4:05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 425 SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5122 WOLVERTON AVE #5			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-02	9. AGE (In years lost birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HIEMAN HYMAN			
14. MOTHER'S MAIDEN NAME RICKLA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT MR. FRED GREENBERG, 5122 WOLVERTON AVE. #15			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91-250.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure (C) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 2 months years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus		1 month	
19A. DATE OF OPERATION 9/10/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/12/68 19 to 9/12/68 19 that (I) (we) last saw the deceased alive on 9/12/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Howard R. Friedman M.D.				23B. DATE SIGNED 9/12/68	
23C. PHYSICIAN'S NAME (Type) HOWARD R. FRIEDMAN M.D.				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-68		24C. NAME OF CEMETERY or CREMATORY KOVNA CONG.	
24D. LOCATION ROSEDALE, MARYLAND		24E. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Finkelman		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-635				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9370	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HYMAN FRIEDMAN		SEPTEMBER 12, 1968 11 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND			
PALL MALL NURSING HOME				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
90				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER		3317 TANEY ROAD	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		87			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
TAILOR		RETIRED		AUSTRIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SIMON FRIEDMAN				DORA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		216-32-5872A		MRS. NATHAN KLEIN, 3317 TANEY ROAD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 day	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				C. V. A.		1 week	
				(B) DUE TO, OR AS A CONSEQUENCE OF:		10 years	
				(C) A S H D			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/11 1946 to 9/12 1968, that (I) (we) last saw the deceased alive on 9/12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
ISRAEL ZINBERG				9/13/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
		4000 W. NORTHERN PARKWAY					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9-13-68		BETH JACOB		FINKSBURG, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 16 1968		Robert E. Finksbury		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9371 CERTIFICATE OF DEATH

REG. NO. 68- 9371

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SOMERS, HARRY EDWIN		2. DATE AND HOUR OF DEATH SEPTEMBER 10, 1968 9:30A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 4315 HIGHVIEW AVE. 21229		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 02/13/12	9. AGE (In years lost birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE SETTER		10B. KIND OF BUSINESS OR INDUSTRY WESTERN ELECTRIC		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WINFIELD SOMERS			14. MOTHER'S MAIDEN NAME HELEN MARBURGER SOMERS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 216-03-5935		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Rupture of Left Ventricle 3-4 hours, color wall. (B) MYOCARDIAL INFARCTION. 15 days. (C) Arteriosclerosis. years.		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 25 1968 to SEPTEMBER 10 1968 , that (I) (we) last saw the deceased alive on SEPTEMBER 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Braulio O. Faano MD.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Braulio O Faano MD.				23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSP RECORDS; CATON & WILKENS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 16 1968			
25A. NAME OF REGISTRAR Robert E. Hubbard		25B. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

IN REPLY TO

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

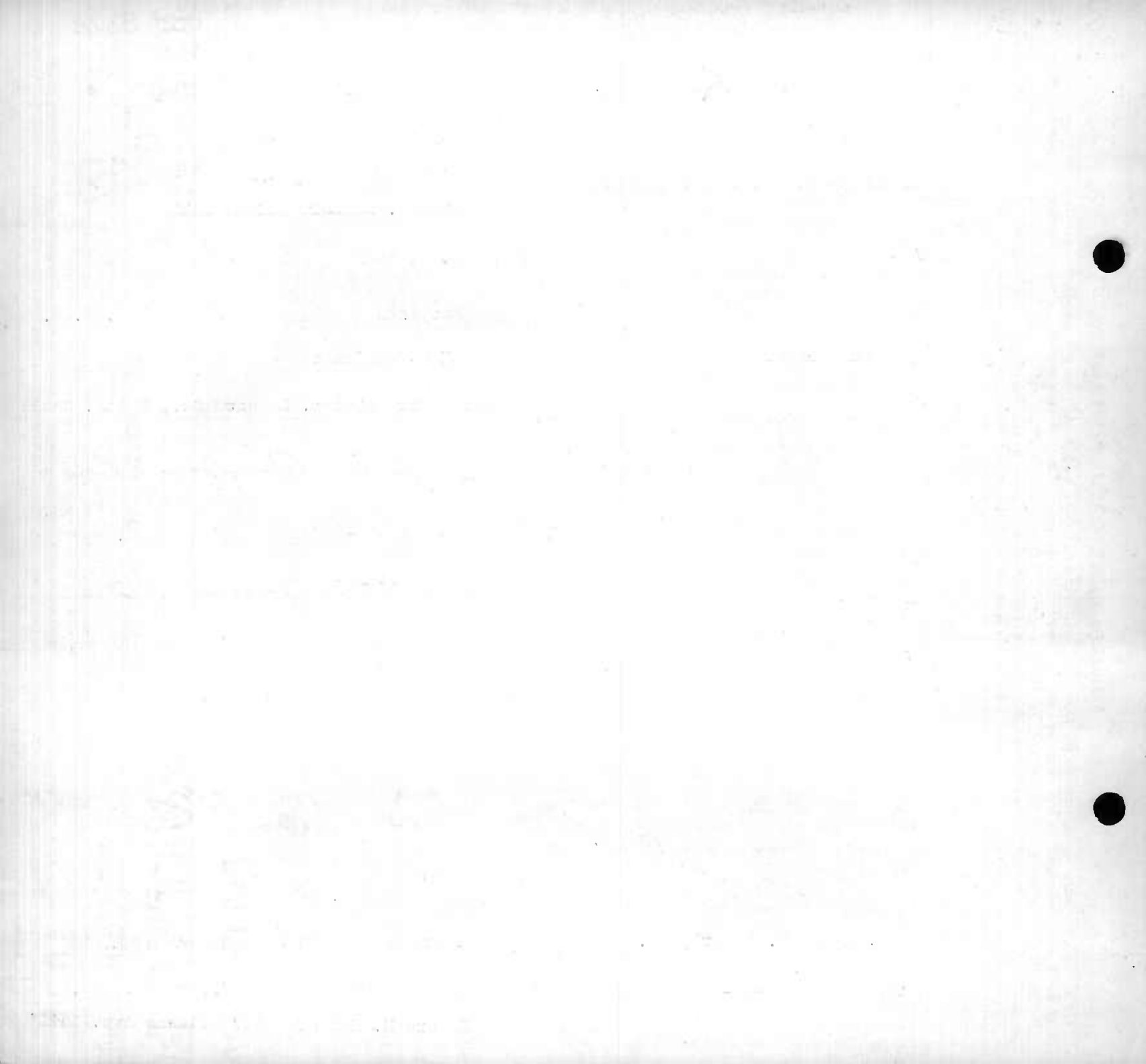
ST. LOUIS HOSPITAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9372 CERTIFICATE OF DEATH

REG. NO. 68- 9372

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>RUTH R. ROBERTS</i>		2. DATE AND HOUR OF DEATH <i>9/12/68</i> <i>440 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>18-03</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital of Baltimore</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>1241 W. Lombard Street 21223</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 9, 1905</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Clark Wenner</i>		14. MOTHER'S MAIDEN NAME <i>Ida Schwitzer</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mary Curry 1241 W. Lombard St., Balto. 21223</i>	
18. <i>183.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>173.70 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cerebral Palsy</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Ca (D) ovary</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>20 hours</i> <i>1 yr</i>		
19A. DATE OF OPERATION <i>9/14/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca Ovary</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/4</i> 19 <i>68</i> to <i>9/12</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/12</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stephen R. Rogers M.D.</i> DEGREE				23B. DATE SIGNED <i>9/12/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Stephen R. Rogers, Md.</i> DEGREE				23D. ADDRESS <i>University Hospital, Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-16-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION <i>Frederick Ave., Balto., Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>SEP 16 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
24G. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		24H. ADDRESS <i>4107 Wilkens Ave. 21229</i>			

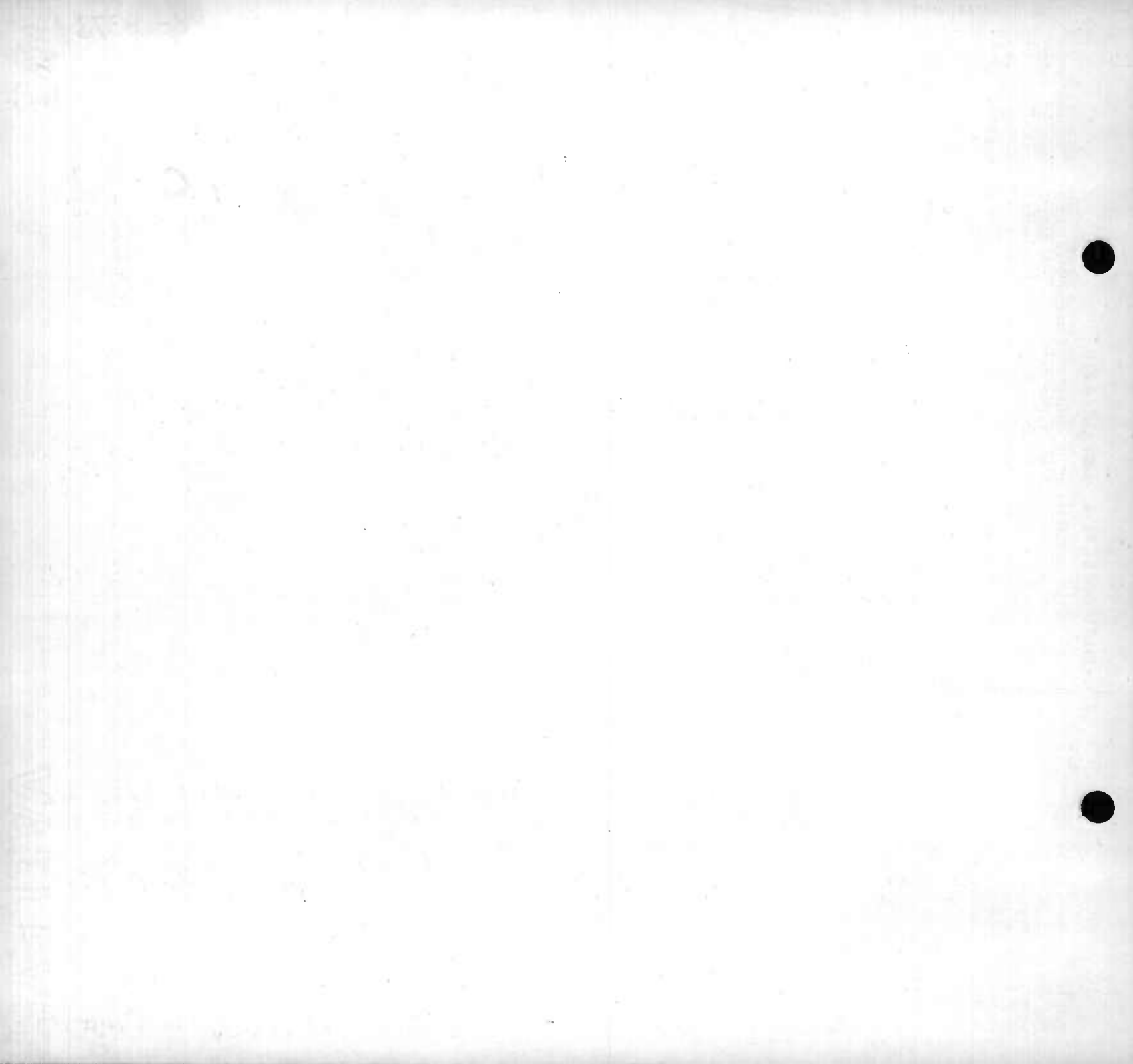


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9373 CERTIFICATE OF DEATH

REG. NO. 68- 9373

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Albert C. Bolek		2. DATE AND HOUR OF DEATH 9-13-1968 800 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 930 E. Eager St. 21202		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-1897	9. AGE (In years lost birthday) 71 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman		10B. KIND OF BUSINESS OR INDUSTRY Hotel Balto. Hotel		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Bolek		14. MOTHER'S MAIDEN NAME Anna Turek	
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 216-05-07404		17. INFORMANT William Bolek Deceased ADDRESS 233 S. Highland Ave	
18. 492X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Respiratory Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral hypoxia (B) DUE TO, OR AS A CONSEQUENCE OF: Emphysema (C) DUE TO, OR AS A CONSEQUENCE OF: Cor pulmonale APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 5-27-11					
19A. DATE OF OPERATION 9-13-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 9, 1968 to Sept. 13, 1968 and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard C. Keech, M.D.				23B. DATE SIGNED 9-13-1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 827 Linden Ave. Baltimore 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-17-68		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Church	
24D. LOCATION (City, town, or county) (State) Baltimore Md. 21206					
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR Edward J. Keech	
				ADDRESS 124 Chasco Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9374 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9374

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE CHAPIN COURSEY		2. DATE AND HOUR OF DEATH SEPT. 11, 1968 10:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 GOULD NURSING HOME 6116 BELAIR ROAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE 21222 C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7618 MEADOW WAY 53-00	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 1, 1895	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIRCULATION DEPT		10B. KIND OF BUSINESS OR INDUSTRY NEWSPAPER		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ROBERT C. COURSEY				14. MOTHER'S MAIDEN NAME MINNIE CHAPIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WWI 215-03-0484		17. INFORMANT MARGARET D. COURSEY ADDRESS AS IN #4 ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.21 CELEBRATE ACCIDENT (Hemiplegia, left) = ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II Hypertension C-V-Disease Hypertrophy prostate				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 mos 54 mos = 104 mos	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from April 22, 1968 to Apr. 11, 1968 , that (I) (we) last saw the deceased alive on Aug. 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.					
23A. SIGNATURE M. B. Davis				23B. DATE SIGNED 9/12/68	
23C. PHYSICIAN'S NAME (Type) M. B. Davis		23D. ADDRESS MD 6800 MORNINGTON RD. DUNDALK, MD 21222			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/13/1968		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE RECEIVED IN HEALTH DEPT. SEP 16 1968			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS W. Brooks Bradley, Dundalk, Md.			

1
0-560

68- 9375

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9375

BIRTH NO.

1. NAME OF DECEASED **THOMAS JOSEPH O'MARA**
(Type or Print)
TOM O'MARA

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
9 10 68 3:20 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
502 W. Fayette St. D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour
September 10, 1968 3:20 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

6. SEX **Male** 7. RACE **White** 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN **Balto.** D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH **July 7, 1925** 10. AGE (In years last birthday) **43** 11. BIRTHPLACE (State or foreign country) **Baltimore, Md.**

E. STREET AND NUMBER **502 W. Fayette St.**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Timothy Joseph O'Mara**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Engineer U.S. Govt. in Japan**

15. MOTHER'S MAIDEN NAME **Treva J. Frank**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **yes WW 2 - Navy 219-18-2214**

18. INFORMANT **Silver Spring, Md. ADDRESS 20902 Mary Walker O'Mara, 2362 Glenmont Circle**

19. **E9531 X** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
E924X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION **2** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No) **YES**

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Home** 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? **502 W. Fayette St. Apt. 7C**
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) **? ? 68 ?** 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? **Subject hanged himself**

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE **Ronald N. Kornblum** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **September 11, 1968**
EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **9/13/68** 24C. NAME OF CEMETERY or CREMATORY **Baltimore National Cem** 24D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

25A. DATE REC'D BY HEALTH DEPT. **SEP 16 1968** 25B. NAME OF REGISTRAR **Robert E. Tarkenton** 25C. FUNERAL DIRECTOR ADDRESS **Schimunek Funeral Home, Inc. 3331 Brehms Lane**

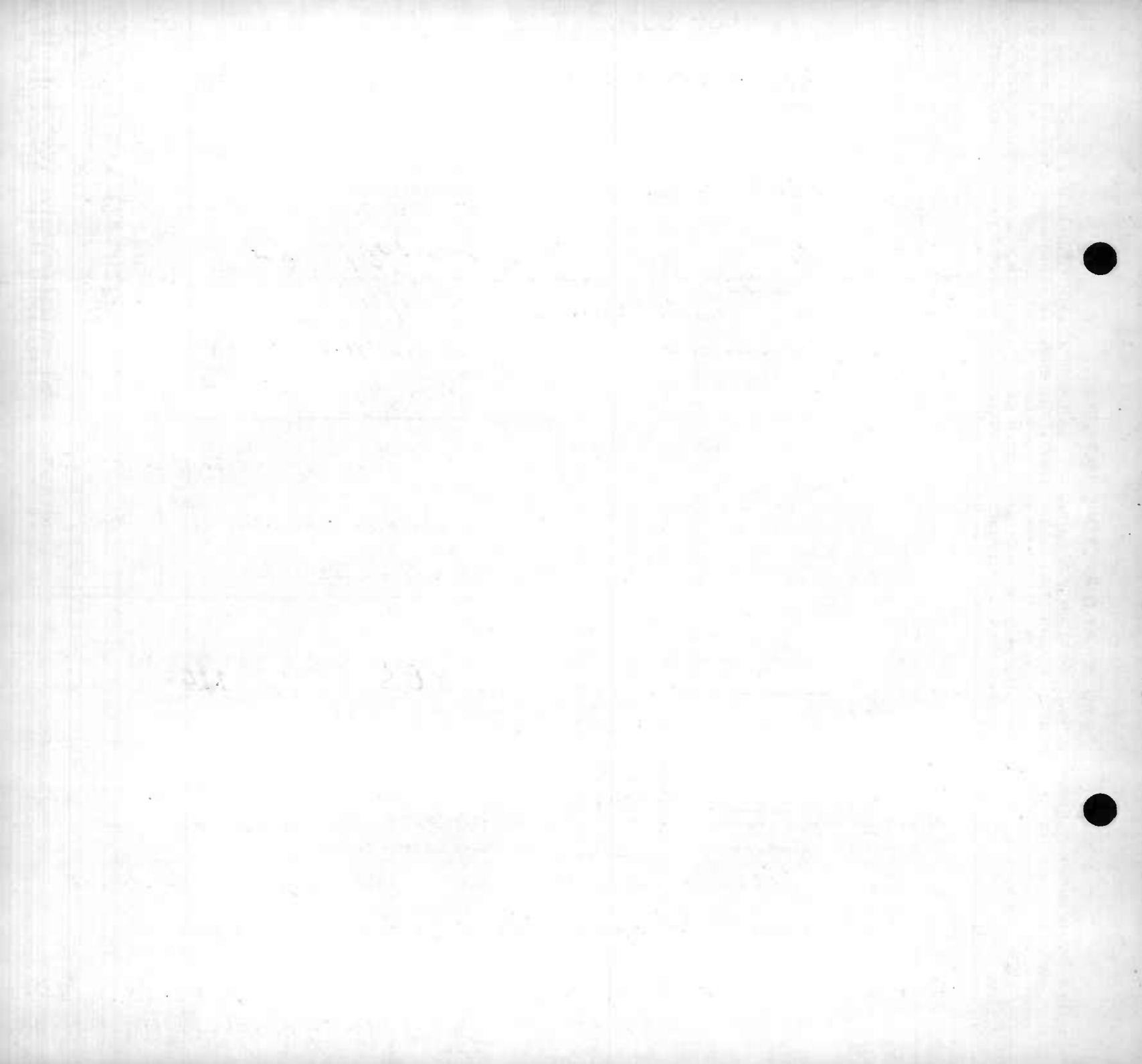
Baltimore, Md.

3333
-Criminology
-Criminology

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9376	
68- 9376 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Margaret M. Collier</i>		2. DATE AND HOUR OF DEATH <i>Sept. 11, 1968</i> <i>5:50A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>52-10</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>91 Montebello Hospital</i>			C. CITY OR TOWN <i>Annapolis</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>53 old Annapolis Blvd. Rt. 5</i>		
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>6-16-1904</i>	9. AGE (In years lost birthday) <i>64</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Civil Service</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>John Kramer</i>		
14. MOTHER'S MAIDEN NAME <i>Mary Rubacker</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Hospital Chart</i>		
18. <i>43391</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral infarction</i> (B) <i>Cerebral artery thrombosis</i> (C) <i>Arteriosclerosis</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>332X II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>1-18 1968</i> to <i>9-11 1968</i> , that (I) (we) lost saw the deceased alive on <i>9-11 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Cesar S. Pellorano M.D.</i>				23B. DATE SIGNED <i>9-11-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Cesar S. Pellorano M.D.</i>				23D. ADDRESS <i>Montebello Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-14-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Forest Hill of Mary</i>	
24D. LOCATION (City, town, or county) <i>DUNDALK MD.</i>		24E. STATE <i>MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 16 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>John M. S. L. L. L.</i>		25D. ADDRESS <i>Annapolis, Md.</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9377

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)APPLEFIELD
NATHAN APPLEFIELD2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

9

11

68

12:20p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

2528 N. Calvert St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 11, 1968

12:20 pm.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

White

Balto.

12 YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Aug 15, 1910

60 58

E. STREET AND NUMBER

2528 N. Calvert St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Maryland

USA

Morris

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Salesman

Rebecca

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

NO

217-03-4828

Mr. L. David Applefield 3434 Vancas Circle

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Cerebral Infarction

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/11/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

9/13/68

Hae Suni

Owens Mills

Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

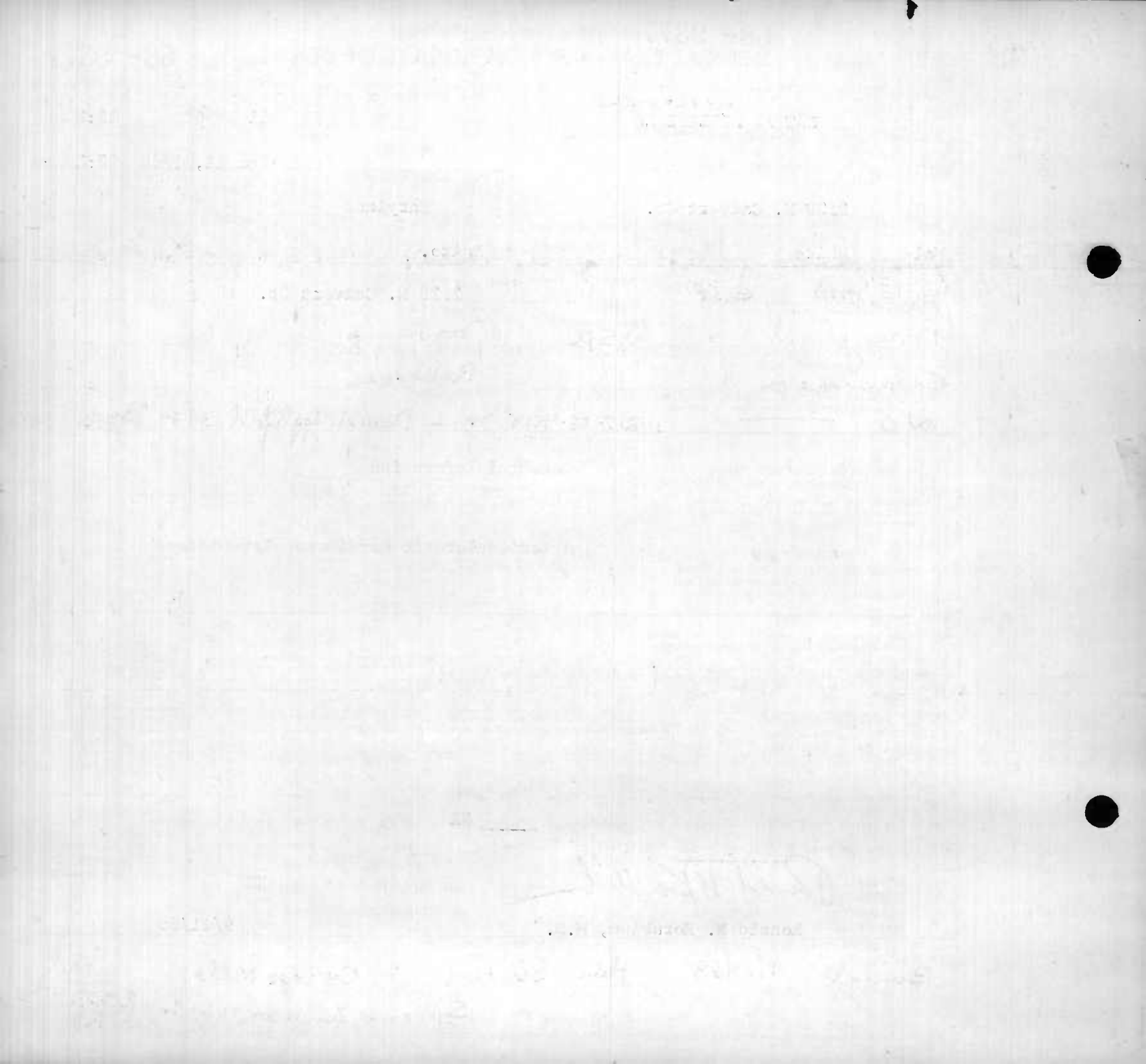
25C. FUNERAL DIRECTOR

ADDRESS

SEP 16 1968

Robert E. Finkbeiner

Sydney S. Levinson, Inc 9610 Reisterstown Rd



BALTIMORE CITY HEALTH DEPARTMENT
68- 9378 CERTIFICATE OF DEATH

REG. NO.

68- 9378

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

H.
KATHERINE PALMER

2. DATE AND HOUR OF DEATH

9-8-68 4:20 pm

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVE.

BALTIMORE, MD. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN
CAMBRIDGE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

400 MARYLAND AVE

21613

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

12-25-00

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

RICHARD A. HOOPER

14. MOTHER'S MAIDEN NAME

CAROLINE Davis

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-24-2491

17. INFORMANT

ADDRESS

BCH RECORDS: 4940 EASTERN AVE. 21224

18. 207.01

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Leukemia

4 weeks

(B)

DUE TO, OR AS A CONSEQUENCE OF:

1

(C)

204.3 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A)

Pneumonia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8 13 0 19 68 to 9 1 8 19 68,
that (I) (we) last saw the deceased alive on 9 1 8 19 68 and that in my (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Qais Ali Awqati

DEGREE

Attending ☐
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

QAIS ALI AWQATI

DEGREE

23D. ADDRESS

BALTIMORE CITY HOSPITALS
4940 EASTERN AVE. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Sept. 11, 1968

24C. NAME of CEMETERY or CREMATORY

Cambridge Cemetery Cambridge Dorchester Maryland

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1968

25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

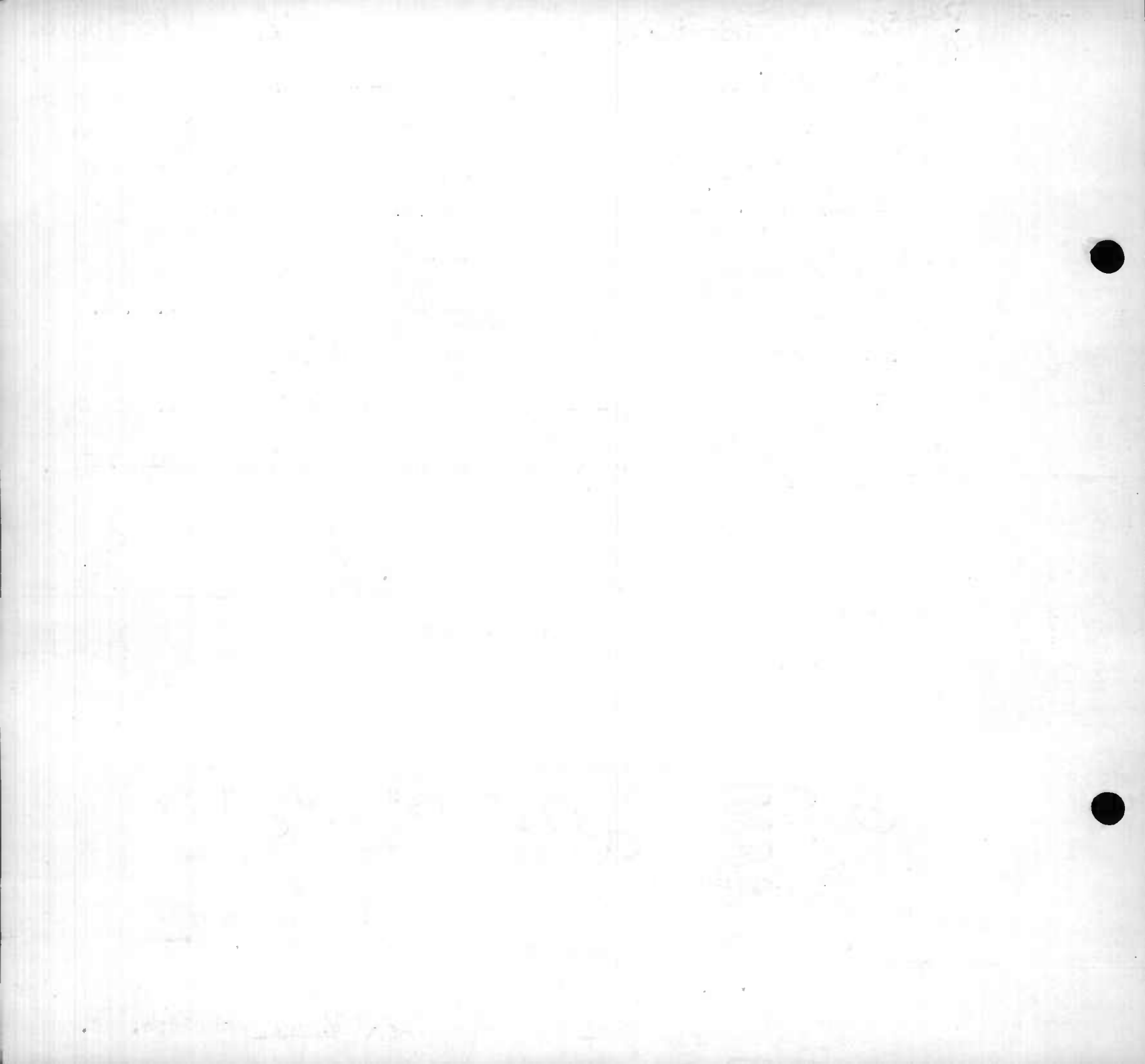
Kenneth R. Shover

ADDRESS

Cambridge, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



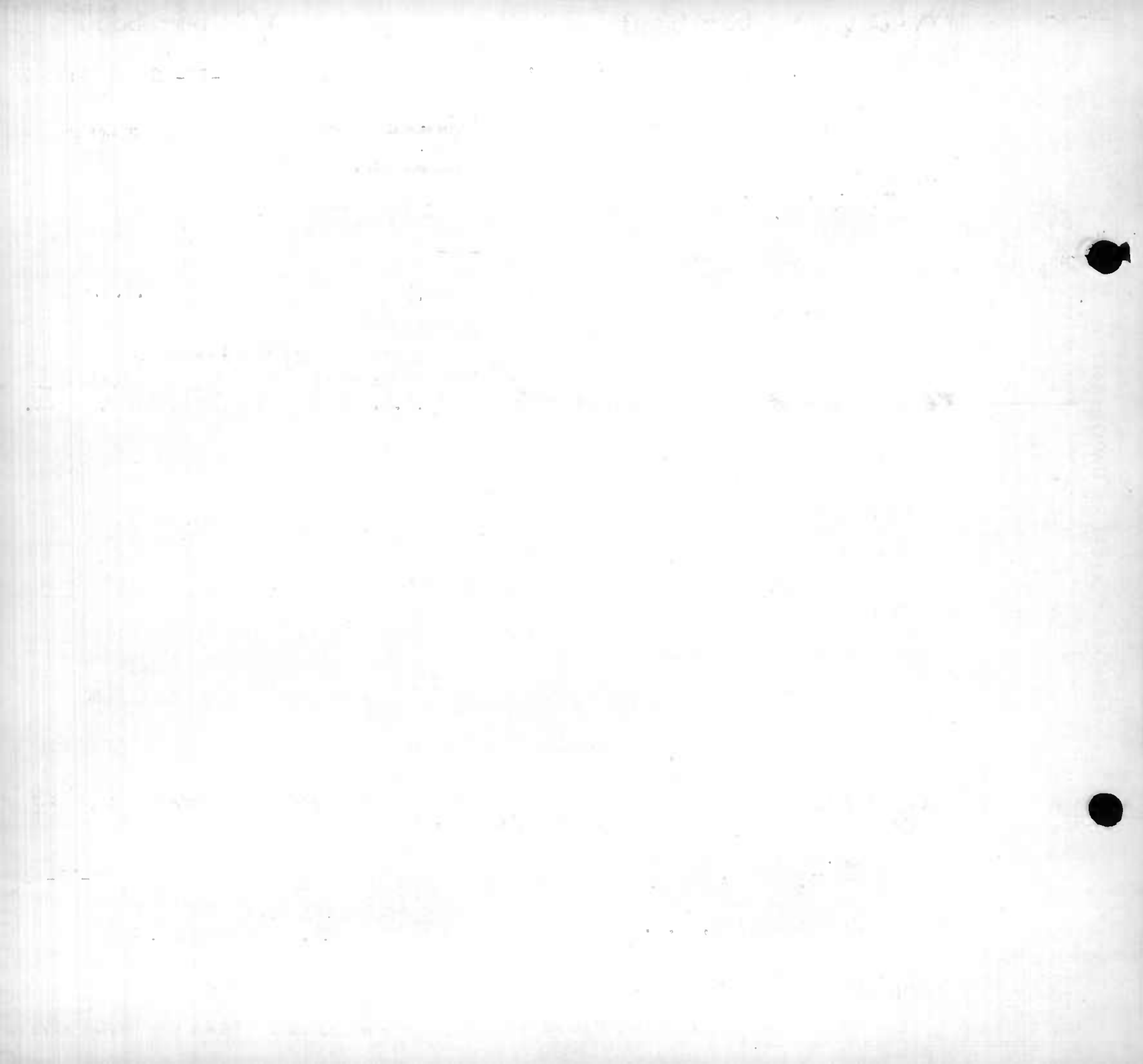
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9379
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
JONES, REVA THERESA		SEPTEMBER 10, 1968 7:35A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY 53-00		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 4305 BARRINGTON RD. 21229		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/23/19	9. AGE (In years last birthday) 49
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME WILLIAM A. GRABER		14. MOTHER'S MAIDEN NAME REVA A. KAEHLER GRABER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 216-03-2272		17. INFORMANT ST. AGNES HOSPITAL RECORDS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 446.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH DIFFUSE GRANULOMATOUS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DISEASE OF UNKNOWN ETIOLOGY (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?
MEDICAL CERTIFICATION				
19. DATE OF OPERATION 2 20. AUTOPSY? (Yes or No) YES				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from AUGUST 10 1968 to SEPTEMBER 10 1968, that (I) (we) last saw the deceased alive on SEPTEMBER 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE R. Revilla		23B. DATE SIGNED 09 10 68		23C. PHYSICIAN'S NAME (Type) R. REVILLA
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Sept 13, 1968		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cemt.
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		
25B. NAME OF REGISTRAR R. Revilla		25C. FUNERAL DIRECTOR Catherine Estate 796 Edmondson Ave. Catonville, Md. 21228		

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9380	
1. NAME OF DECEASED (Type or Print) MEAGHER, MARSHALL		2. DATE AND HOUR OF DEATH 9/11/68 9-11-68 3:58:40 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE MD. 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? XX YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1402 THIRD ROAD 21220			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-29-20	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN			
14. MOTHER'S MAIDEN NAME SADIE M. CLINICK		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II			
16. SOCIAL SECURITY NO. 212-18-1707		17. INFORMANT Records: B.C.H. RECORDS 4940 EASTERN AVE. MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5-69-91		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO-PULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 5-78 X II		(B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE UPPER G.I. HEMORRHAGE		218 hrs	
		(C) DUE TO, OR AS A CONSEQUENCE OF: HYPOTENSIVE SHOCK		17 hrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CHRONIC LONG DISEASE ESSENTIAL HYPERTENSION					
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from Sept. 10, 1968 to Sept. 11, 1968 , that (1) (we) last saw the deceased alive on Sept. 11, 1968 and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Kaplan M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 9/11/68		
23C. PHYSICIAN'S NAME (Type) Joseph Kaplan, M.D.		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9/14/68	24C. NAME of CEMETERY or CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D. BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Ishiyama		25C. FUNERAL DIRECTOR J.E. CONNELLY SONS 300 MACE	



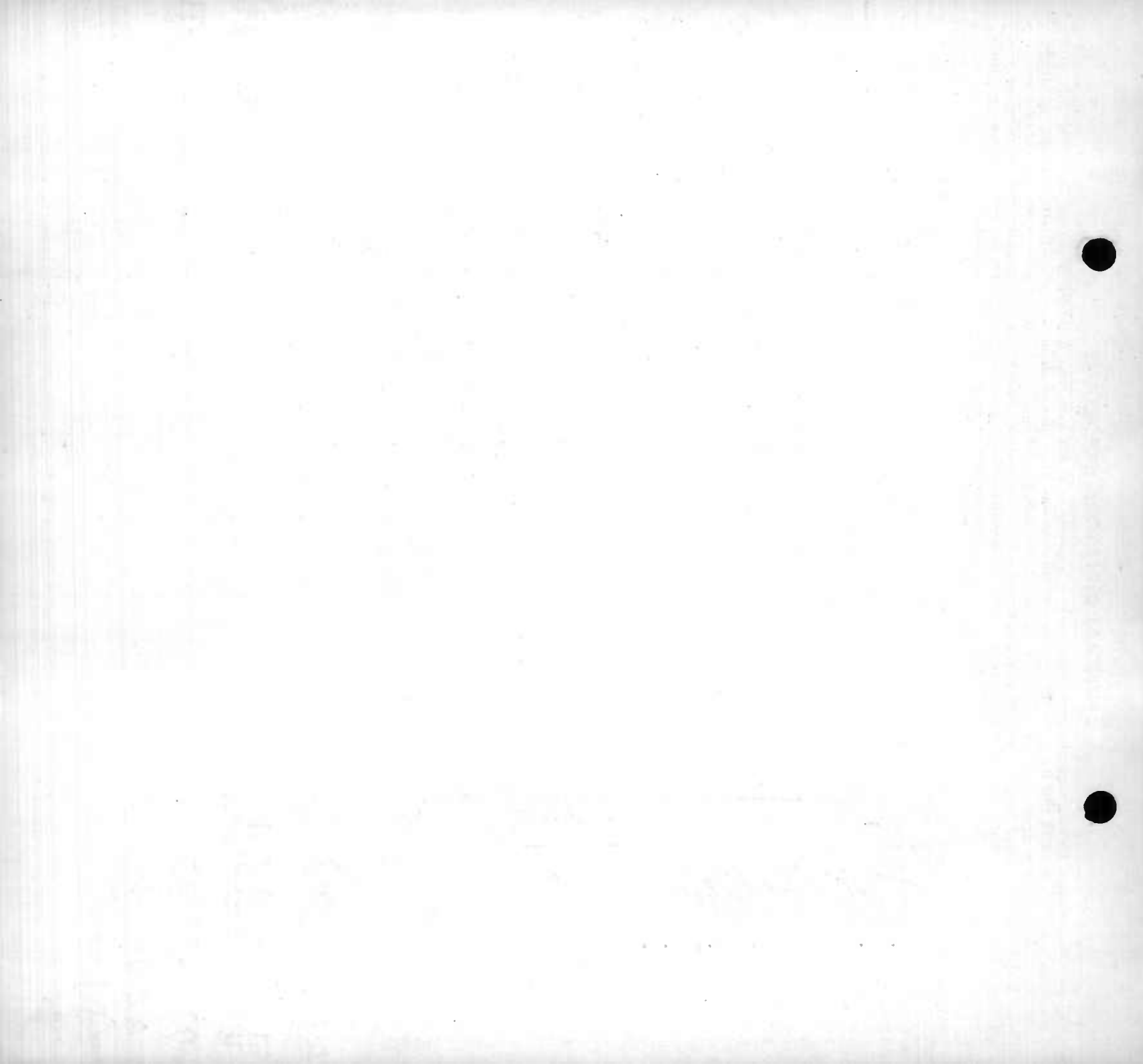
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9381 CERTIFICATE OF DEATH

REG. NO. 68- 9381

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elsie Mae Clark		2. DATE AND HOUR OF DEATH 9-12-68 6 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 28-04	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Uplands Home for Aged				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER Uplands Home for Aged	
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1887	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Manheim, Pa.	
13. FATHER'S NAME Caton Smith			14. MOTHER'S MAIDEN NAME Emily Burkholder		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Mrs. Helen Cox	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CEREBROVASCULAR ACCIDENT (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD WITH SENILE DEMENTIA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) none					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 YEARS					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II					
19A. DATE OF OPERATION 9		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1 Aug 19 68 to 13 Sept 19 68 , that (I) (was) last saw the deceased alive on 11 Sept 19 68 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE W. K. Gallagher, Jr., M.D. DEGREE MD				23B. DATE SIGNED 9/12/68	
23C. PHYSICIAN'S NAME (Type) W. K. Gallagher, Jr., M.D.		23D. ADDRESS 6630 Baltimore National Pike 21228			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/14/68	24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Wm. J. Tickner & Sons - Balt., Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9382 CERTIFICATE OF DEATH

REG. NO. X

68- 9382

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KESSLER, FRANCIS G.

2. DATE AND HOUR OF DEATH

9-11-68

10:12A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)ST. AGNES HOSP. WILKENS & CATON
BALTIMORE, MD. 212294. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND, CATONSVILLE 53-00

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

1 ARTHUR AVE.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

02-16-88

9. AGE (In years
last birthday)

80

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED ; FIREMAN

10B. KIND OF BUSINESS OR INDUSTRY

BALTO. & OHIO RR

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

705-05-5951

17. INFORMANT

ADDRESS

ST. AGNES RECORDS ; WILKENS & CATON

18. 410.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Myoc. Infarction 1 day

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Old Myocardial Infarction years

(C)

ASCVD years

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from 9-11 19 68 to 9-11 19 68,
that ☒ (we) last saw the deceased alive on 9-11-68 19 and that in ☒ (our) opinion death occurred on the date
and hour and from the causes stated above. ☒ (We) (did) ☒ view the body after death.

23A. SIGNATURE

Ralph E. Updike M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12 Sept 68

23C. PHYSICIAN'S
NAME (Type)

RALPH E UPDIKE

DEGREE

23D. ADDRESS

ST. AGNES HOSP. WILKENS & CATON AVE.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/14/68

24C. NAME OF CEMETERY or CREMATORY

Loudon PK Cem

24D. LOCATION

BALTO.

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1968

25B. NAME OF REGISTRAR

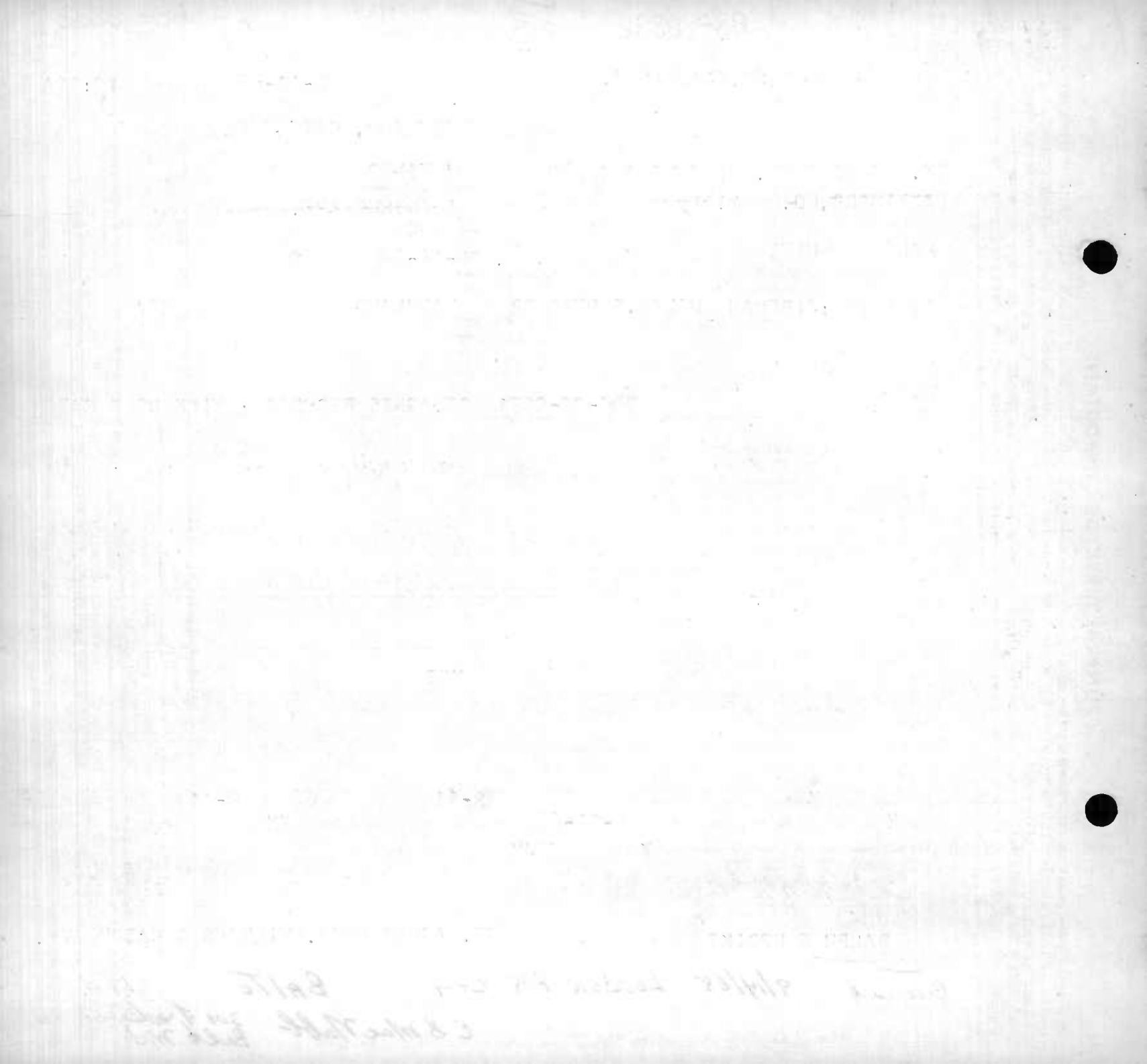
Robert E. Tabor

25C. FUNERAL DIRECTOR

E. B. MacNabb

ADDRESS

301 Frederick Rd
Baltimore Md



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9383 CERTIFICATE OF DEATH

REG. NO. **68- 9383**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) NAGEL, Sister Louise, D. C.		2. DATE AND HOUR OF DEATH 9-13-68 2:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21207			
FULL NAME OF HOSPITAL OR INSTITUTION 21 Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215		C. CITY OR TOWN Baltimore INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 Forest Hill Road			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-13-87	9. AGE (In years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS SISTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rensselaire, Indiana	
13. FATHER'S NAME George Nagel		14. MOTHER'S MAIDEN NAME Dorothy Flachen Trager			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 219-54-0662J1		17. INFORMANT ADDRESS Records Seton Institute City 21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 230.5 T		CAUSE OF DEATH (A) IMMEDIATE CAUSE Tumor of liver; primary; not specified DUE TO, OR AS A CONSEQUENCE OF: (B) Hepatic coma DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months 8 days 4 weeks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 156.2 II		Acute brain syndrome, associated with metabolic disturbance			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-8-68 19 to 9-13-68 19, that (I) (we) last saw the deceased alive on 9-13-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Walter O. Jahrreiss M.D.</i>				23B. DATE SIGNED 9-13-68	
23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss M. D.				23D. ADDRESS Seton Psychiatric Institute	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE Sept-14-68		24C. NAME of CEMETERY or CREMATORY St. Joseph's Cemetery	
24D. LOCATION (City, town, or county) (State) Emmitsburg, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968			
25B. NAME OF REGISTRAR <i>Robert E. Jarboe</i>		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co. 108-W-North-Av 21201			

1820-1821

1820-1821
1820-1821
1820-1821
1820-1821
1820-1821

1820-1821
1820-1821
1820-1821
1820-1821
1820-1821

1820-1821
1820-1821
1820-1821
1820-1821
1820-1821

1820-1821
1820-1821
1820-1821
1820-1821
1820-1821

1820-1821
1820-1821
1820-1821
1820-1821
1820-1821

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9384				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9384	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) HENRY J. McARTHUR				9/13/68 5:45 A.M.			
3. PLACE IN BALTIMORE-MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL.				A. STATE MD. B. COUNTY Reisterstown			
				C. CITY OR TOWN Reisterstown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 2 Cherry Hill Rd.			
5. SEX M	6. RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/11		9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry J. McCarthy				14. MOTHER'S MAIDEN NAME Willetta Trott			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220 18 6244		17. INFORMANT Wife	
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A' CARCINOMA ESOPHAGUS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 150X II				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 8/25/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adherent loop of Jejunum		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? I	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-25-68 19 68 to 9/13/68 19 68 , that (I) (we) last saw the deceased alive on 9/13/68 19 68 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE H. G. Martinez M.D.				23B. DATE SIGNED 9/13/68		23C. PHYSICIAN'S NAME (Type) H. G. MARTINEZ M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 16, 68		24C. NAME OF CEMETERY or CREMATORY New Oakland Cem		24D. LOCATION (City, town, or county) (State) Union Bridge Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Loring Byers		25D. ADDRESS Funeral Home 8728 Liberty Rd. Randallstown Md.	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11/18/01 BY 60322 UCBAW

DATE 11/18/01 BY 60322 UCBAW
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11/18/01 BY 60322 UCBAW

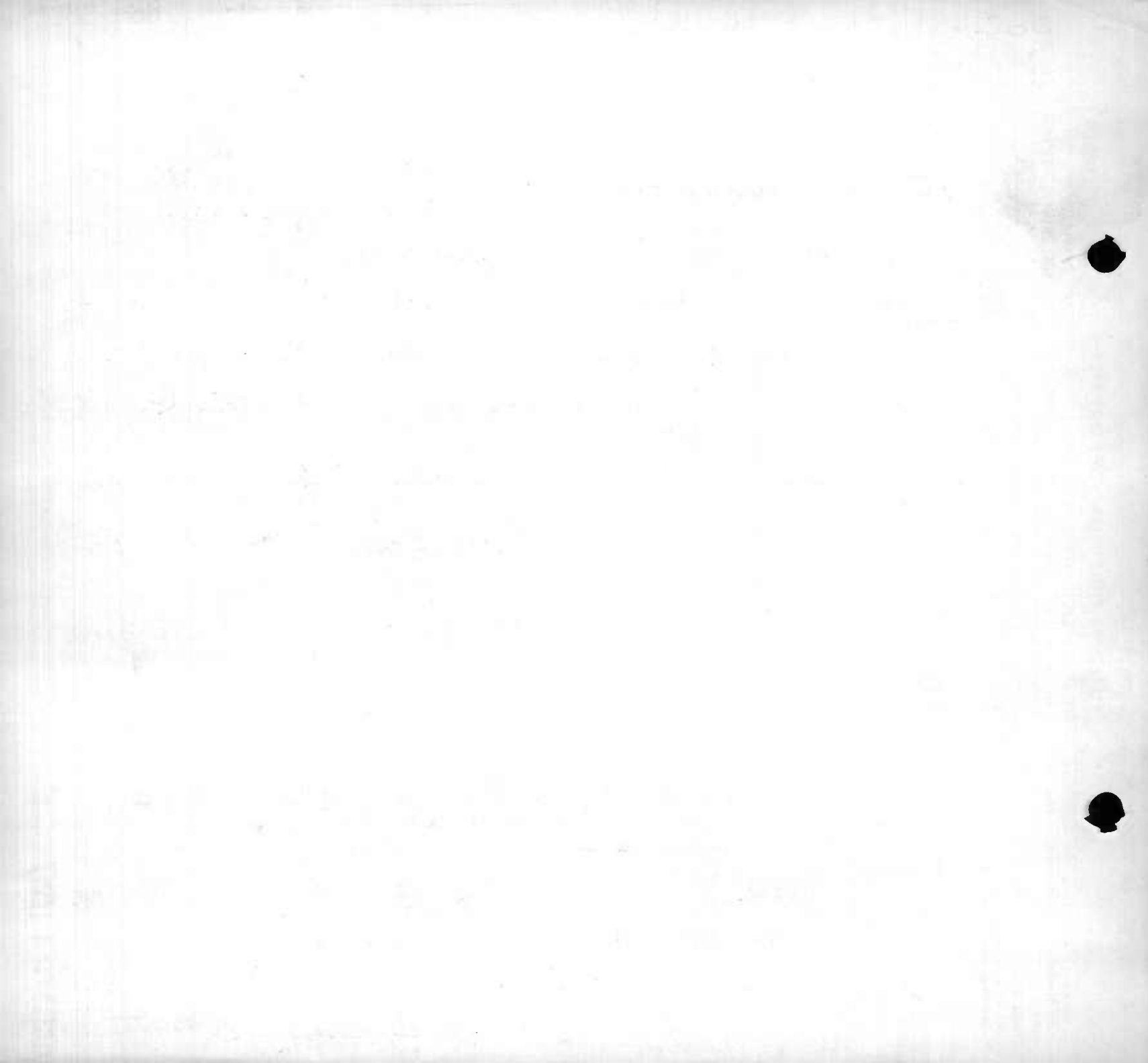
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11/18/01 BY 60322 UCBAW

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11/18/01 BY 60322 UCBAW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9385	
68- 9385		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALBERT J. STENGEL	
2. DATE AND HOUR OF DEATH SEPT. 10, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MD. B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 16, 1900	
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CASPER STENGEL		14. MOTHER'S MAIDEN NAME MARY FORTMANN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 18-34-9884	
17. INFORMANT Mrs. Margaret E. Stengel - 511 Rock Glen		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.94-250.9 Cerebral Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis		(B) years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.11 II Diabetes Mellitus		(C) years	
19A. DATE OF OPERATION 9/10/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/10/68 to 9/10/68 , that (I) (we) last saw the deceased alive on 9/10/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 9/12/68	
23C. PHYSICIAN'S NAME (Type) S. J. Nolan MD		23D. ADDRESS Baltimore Md.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9-14-68	
24C. NAME OF CEMETERY or CREMATORY Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Frederick - Carney & Co.		ADDRESS 1000 E. Baltimore Ave.	

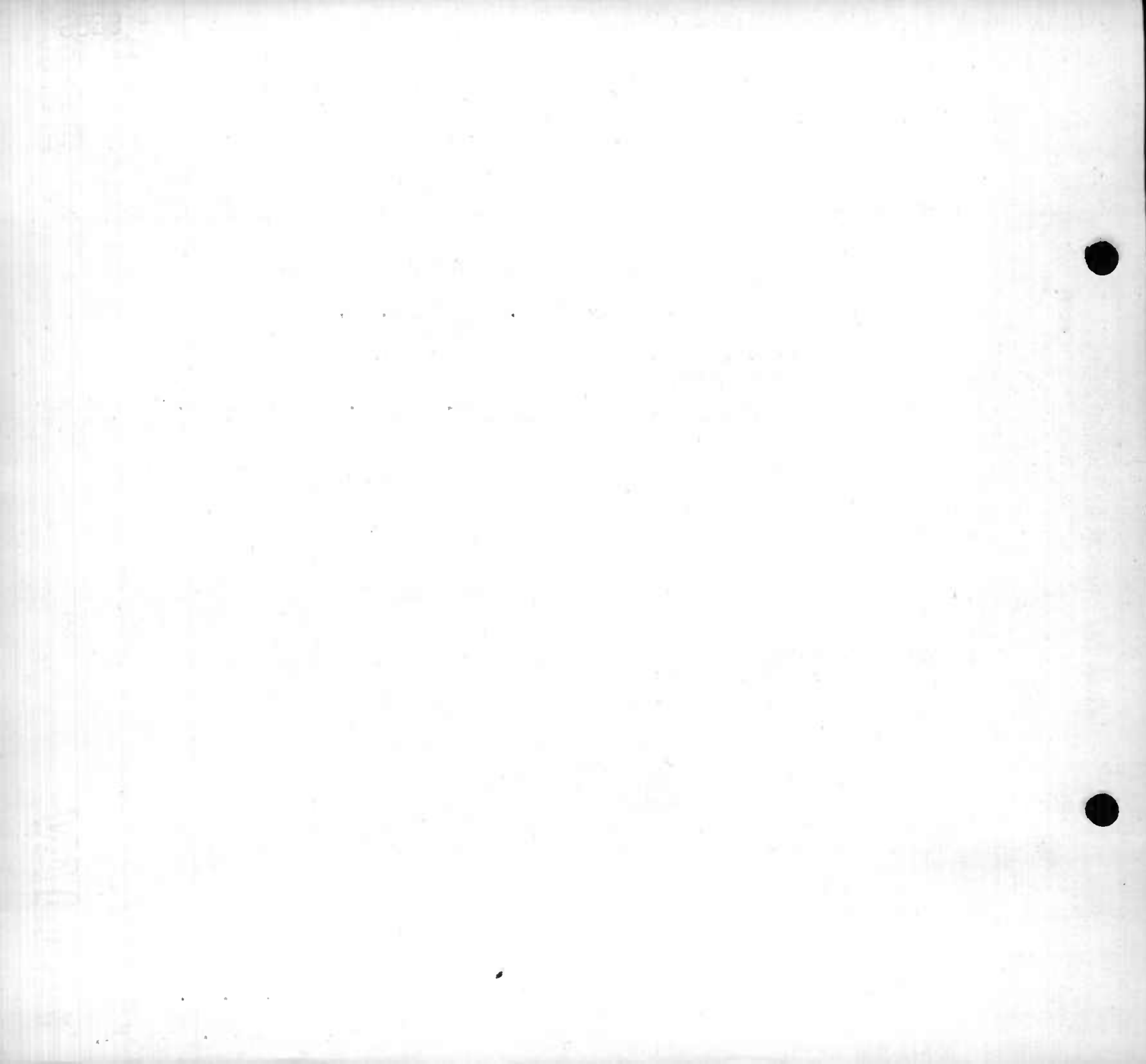


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9386 CERTIFICATE OF DEATH

REG. NO. 68- 9386

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William T. Hubbard</i>		2. DATE AND HOUR OF DEATH <i>9-13-68</i> <i>4:15</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 THE JOHNS HOPKINS HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE CITY</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? <i>YES</i> E. STREET AND NUMBER <i>416 EAST GITTINGS STREET 21230</i>	
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>XXXX</i> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-02</i>	9. AGE (In years last birthday) <i>66</i>	10. Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Sand & Gravel Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>William Hubbard</i>			
14. MOTHER'S MAIDEN NAME <i>Jennie Hammond</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Clara C. Hubbard 416 E. Gittings St</i>			
18. <i>15-7.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>heart failure</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>hypovolemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>metastatic cancer of the pancreas</i>		<i>1 week</i>	
(C) <i>gastroc fistula</i>		<i>delusance of abdominal</i>		<i>4 wks post op</i>	
19. DATE OF OPERATION <i>08/15/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ca of pancreas</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 1</i> 19 <i>68</i> to <i>Sept 13</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Sept 13</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Vincent F Reale</i>				23B. DATE SIGNED <i>9/13/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>VINCENT F? REALE</i>				23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9 16 68</i>		24C. NAME of CEMETERY or CREMATORY <i>Loddon Park</i>	
24D. LOCATION <i>Balto. Md.</i>		24E. (City, town, or county) (State)			
25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 16 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Mc Cully 130 E. Fort Ave.</i>	



1
5-365

68- 9387 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9387

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLEMENT STROMBURG		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour September 9, 1968 6:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 9, 1968 6:50 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH FEB. 10 - 1916		10. AGE (In years last birthday) 58	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Stromberg		14. MOTHER'S MAIDEN NAME MARGARET A. Schroem	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCANTILE TRUST CO. Guard		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W W I	
17. SOCIAL SECURITY NO. 216-03-58299		18. INFORMANT Mary Stromberg	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 412.4 - 250.9	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Diabetes Mellitus		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/13/68	
24C. NAME OF CEMETERY or CREMATORY Cathedral Cem		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR FARLEY		25D. ADDRESS FUNERAL HOME Cavanaugh 6601 FREDERICK AVE	

[Faint, mostly illegible text at the top of the page, possibly bleed-through from the reverse side.]

[Faint, mostly illegible text in the middle section of the page.]

[Faint, mostly illegible text at the bottom of the page.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 9388</u>
BIRTH NO.		68- 9388		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MELANIA W. STANGE		SEPT 13, 1968 0600 HAS M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
UNION MEMORIAL HOSPITAL.		A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 44		C. CITY OR TOWN. LUSHERVILLE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 105 DUBLIN DRIVE.		
5. SEX FEMALE	6. RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-07	9. AGE (In years lost birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) EUROPE
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME BASIL MATOSKY		
14. MOTHER'S MAIDEN NAME JULIA LOTOSKY.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Melvin W. Stange- 105 Dublin Drive		
18. 1977-7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CANCER - (B) WOLFPENET METASTASIS TO LIVER DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 months.
15-6-2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from SEPT 5 1968 to SEPT 13 1968, that (I) (we) last saw the deceased alive on SEPT 13 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Richard C. W. Hall MD.		23B. DATE SIGNED SEPT 13, 1968		23C. PHYSICIAN'S NAME (Type) RICHARD C. W. HALL MD.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/68		24C. NAME OF CEMETERY or CREMATORY Parkwood
24D. LOCATION Baltimore		24E. (State) Md		
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd

Page 1 of 1

10-10-07

10-10-07

10-10-07

10-10-07

10-10-07

10-10-07

10-10-07

10

10-10-07

10-10-07

10-10-07

10-10-07

10-10-07

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9389 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9389

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Patrick D. Brennan

2. DATE AND HOUR OF DEATH

9/10/1968

10:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1808 Thornbury Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md. Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1808 Thornbury Rd.

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8 28 1885

9. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ret. Mgr.

10B. KIND OF BUSINESS OR INDUSTRY

Life Insurance

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF WHAT COUNTRY?

U S A.

13. FATHER'S NAME

William Brennan

14. MOTHER'S MAIDEN NAME

Sarah

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213 05 5777

17. INFORMANT

ADDRESS

Elizabeth Brennan 1808 Thornbury Rd.

18. 412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Arteriosclerotic cardio-vascular disease

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

15 yrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 19 58 to September 10 19 68
that (I) (we) lost saw the deceased alive on September 3, 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Lloyd E. Saylor

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

Sept. 12, 1968

23C. PHYSICIAN'S
NAME (Type)

Lloyd E. Saylor

23D. ADDRESS

3902 Greenmount Ave.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/12/1968

24C. NAME of CEMETERY or CREMATORY

Druid Ridge Cemetery

24D. LOCATION

(City, town, or county)

(State)

Pikesville, Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1968

25B. NAME OF REGISTRAR

Robert E. Saylor

25C. FUNERAL DIRECTOR

Mitchell Wiedefeld Home 6500 York Rd.

ADDRESS

Arteriosclerotic cardio-15 yrs.
vascular disease

No

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9390 CERTIFICATE OF DEATH

REG. NO. 68- 9390

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Leroy Hanway Kenly		2. DATE AND HOUR OF DEATH September 11, 1968 7⁰⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-14			
FULL NAME OF HOSPITAL OR INSTITUTION Edgewood Nursing Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 407 Hawthorne Road					
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1874	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James F. Kenly		14. MOTHER'S MAIDEN NAME Sarah Hanway	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-8282		17. INFORMANT Mrs. J. Stewart Clark S^{ame}	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis Instant		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized Arteriosclerosis 5 yrs		(B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Sclerosis 5 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-1-1955 to 9-11-1968 , that (I) was last saw the deceased alive on 9-9-1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. 9:25 A.M.					
23A. SIGNATURE Robert H. Siver		23B. DATE SIGNED 9-11-68		23C. PHYSICIAN'S NAME (Type) Dr. Robert H. Siver	
23D. ADDRESS 3105 N. Charles St. Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-68		24C. NAME of CEMETERY or CREMATORY All Faith Episcopal Church	
24D. LOCATION (City, town, or county) (State) St. Mary's Co., Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Siver		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.	
				ADDRESS 6500 York Rd. Baltimore, Md.	

Testimony of the witness
in the case of the
State of New York
vs. the People

11-11-11
11-11-11
11-11-11

John H. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9391 CERTIFICATE OF DEATH

REG. NO. 68- 9391

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM BERNARD HYSAN		2. DATE AND HOUR OF DEATH 9-14-68 9 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 12-01			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 225 WENDOVER RD.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-96	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT-RETIRED COLUMBIA SPECIALTY CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. E. Hysan, Sr.		14. MOTHER'S MAIDEN NAME SARAH RYAN		ADDRESS 225 WENDOVER RD. 21218	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWT		16. SOCIAL SECURITY NO. 213-01-0960A		17. INFORMANT MISS GENEVIEVE A. DAVIS	
18. 185X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UREMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. URINARY INFECTION CARCINOMA OF PROSTATE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 177X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from JULY 31 1968 to SEPT. 14 1968 , that (I) (we) last saw the deceased alive on SEPT. 14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel Mendes Ribeiro		23B. DATE SIGNED 9/14/68		23C. PHYSICIAN'S NAME (Type) MANUELA MENDES RIBEIRO, M.D.	
23D. ADDRESS MERCY HOSPITAL - BALTO. MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/17/68	24C. NAME OF CEMETERY or CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968	25B. NAME OF REGISTRAR R. E. & E. Johnson	25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

RECEIVED
STATE OF TEXAS
JAN 15 1901

25 11 1901

RECEIVED
JAN 15 1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9392 CERTIFICATE OF DEATH

REG. NO. 68- 9392

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RONALD G. DEMUTH		2. DATE AND HOUR OF DEATH SEPT 14 1968 1:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 730 E LAKE AVE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-26-06	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY CHESAPEAKE Rim Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES S. DEMUTH			14. MOTHER'S MAIDEN NAME MARIE GRAY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-1928		17. INFORMANT MRS. JUANITA S. DEMUTH	
				ADDRESS ABOVE	
18. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSION 210/120			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II			HYPERTENSIVE C.V.D., A.S.V.D.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-11 1968 to 9-14 1968 , that (I) (we) last saw the deceased alive on 9/14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard C. W. Hall M.D.				23B. DATE SIGNED 9/14/68	
23C. PHYSICIAN'S NAME (Type) RICHARD C. W. HALL, M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-16-68	24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR G. E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.	

SEP 16 1968

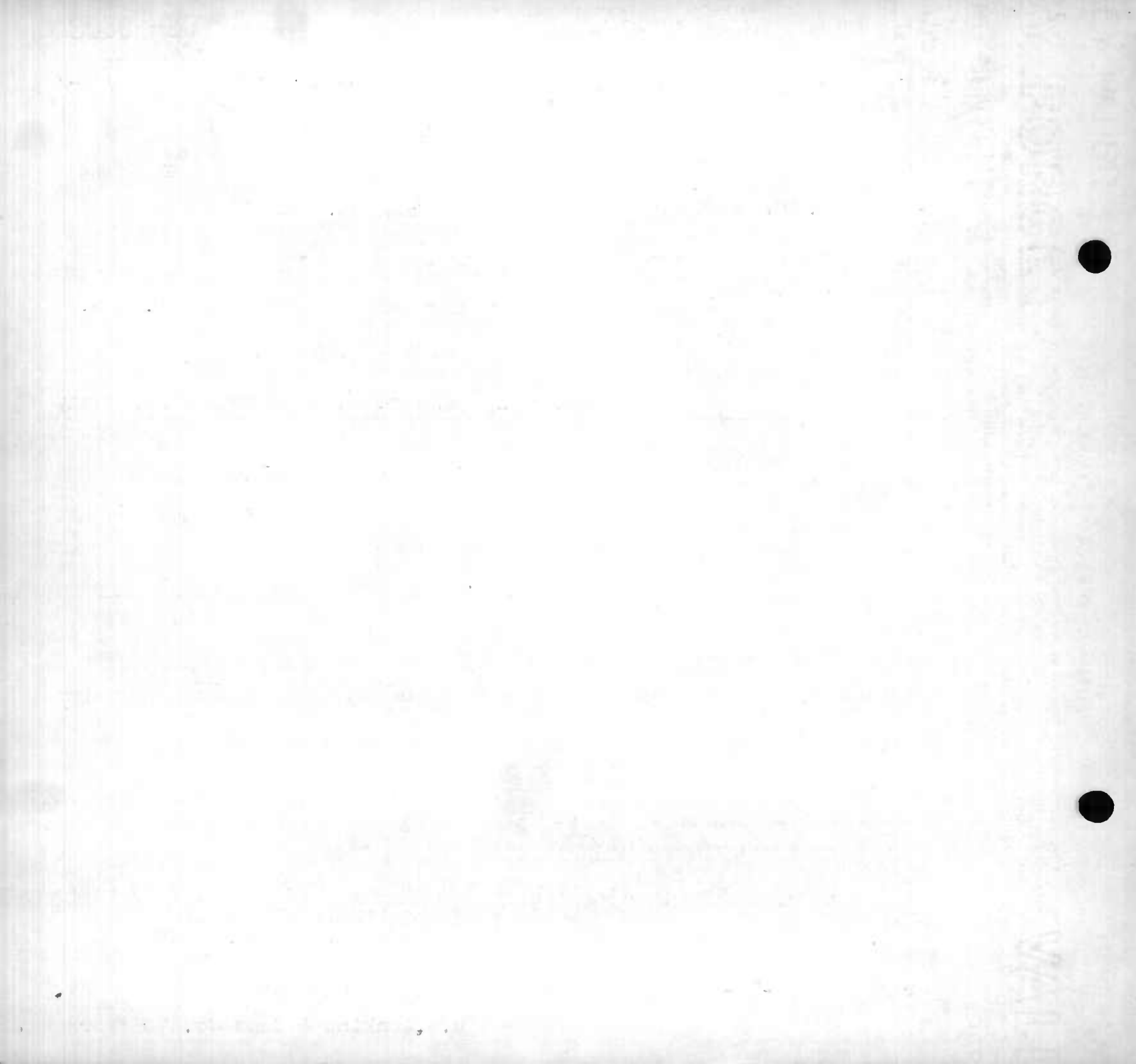
THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX AND TILDEN FOUNDATIONS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-520		68-9393		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9393	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) PAUL A. DEEMS			
2. DATE AND HOUR OF DEATH 9-13-68 1:45 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 11-02				5. SEX MALE 6. RACE WHITE			
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
E. STREET AND NUMBER 835 PARK AVE. 21201				10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ADAM DEEMS				14. MOTHER'S MAIDEN NAME AUGUSTA KAHL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-38-9567-A			
17. INFORMANT BCH RECORDS: 4940 EASTERN AVE. 21224				ADDRESS			
18. 7-36.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 331X II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
19A. DATE OF OPERATION 2				20A. AUTOPSY? (Yes or No) YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) this hospital attended the deceased from 9-8 19 68 to 9-13 19 68 , that (I) (we) last saw the deceased alive on 9-13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Chris Stucky MD				23B. DATE SIGNED 9-13-68			
23C. PHYSICIAN'S NAME (Type) R. CHRIS STUCKY MD				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-17-68			
24C. NAME OF CEMETERY or CREMATORY Loudon Park				24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968				25B. NAME OF REGISTRAR Robert E. Jenkins			
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd.			



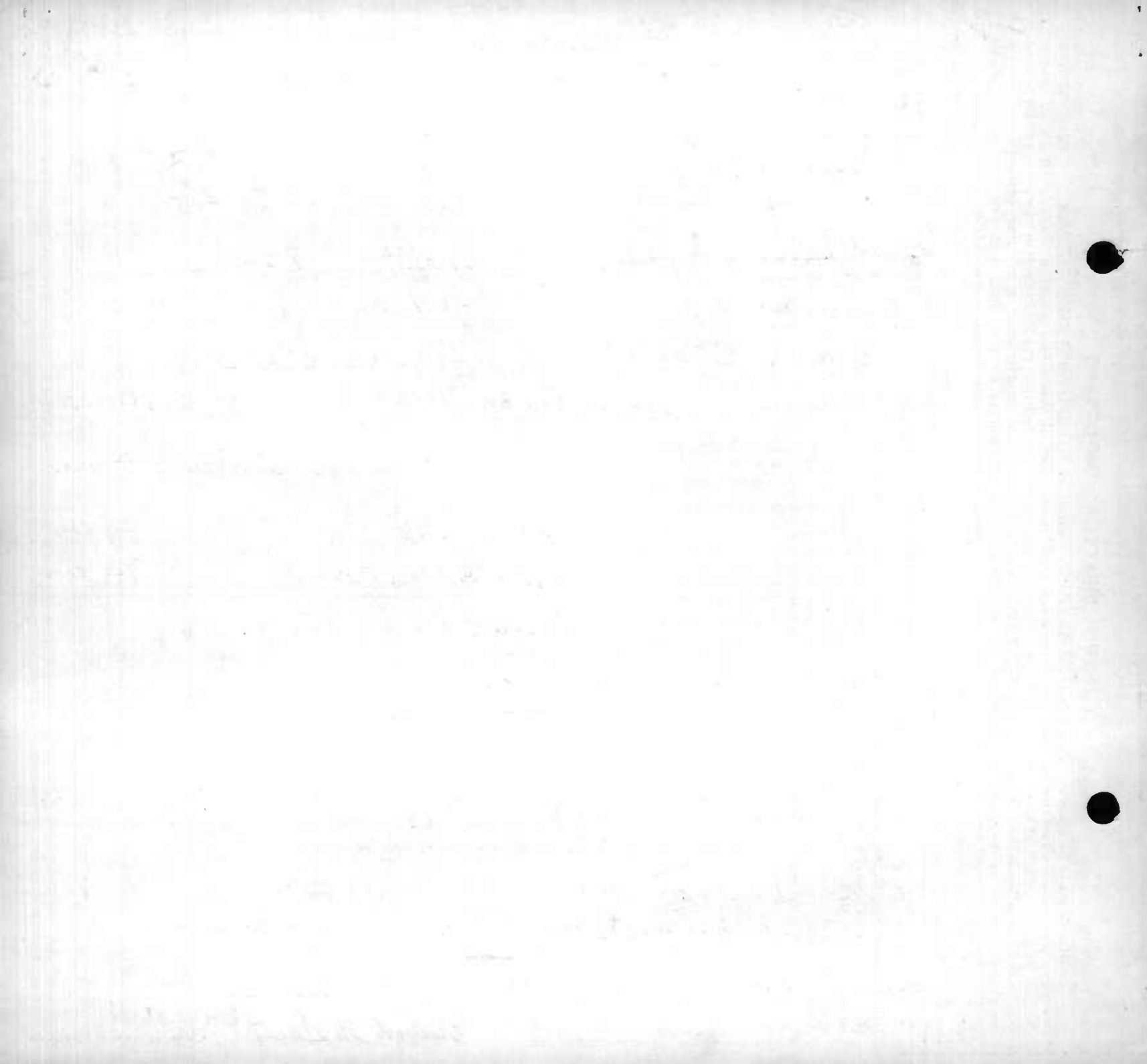
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9394 CERTIFICATE OF DEATH

REG. NO. 68- 9394

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LOUIS J. STOLLOF		2. DATE AND HOUR OF DEATH 9-11-68 12 ¹⁰ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL of BALTIMORE, 42 BALTIMORE MD.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES NO
			E. STREET AND NUMBER 5008 Litchfield Ave #15		
5. SEX M	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/86	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FUNERAL WORKER			11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME SIMON. STOLLOF			14. MOTHER'S MAIDEN NAME LENA COPELAND		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes. WWI		16. SOCIAL SECURITY NO. 306-10-1168A	17. INFORMANT HELEN FREEDMAN ADDRESS 5008 LITCHFIELD AVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.91 CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD. EBM. DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 260X II BENIGN PROSTATIC HYPERTROPHY					
19A. DATE OF OPERATION 9-11-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BENIGN PROSTATIC HYPERTROPHY		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-6-1968 to 9-11-1968 , that (I) (we) last saw the deceased alive on 9-11-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cecile Abrahamowitz M.D.				23B. DATE SIGNED 9-11-68	
23C. PHYSICIAN'S NAME (Type) CECILE ABRAMOWITZ, M.D.				23D. ADDRESS SINAI HOSP of BALTO. INC.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-16-68		24C. NAME OF CEMETERY or CREMATORY HOLY ROSEARY CARMEL HILLSIDE near Gary Ind Illinois	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Searcy		25C. FUNERAL DIRECTOR Frank J. Searcy ADDRESS 814 W 36 St BALTIMORE Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9395 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9395

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alexander, Mr. ^{HARRY} Charles		9.10.68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital				A. STATE Maryland	
				B. COUNTY Baltimore	
5. SEX M				6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Dec 12, 1901	
9. AGE (In years last birthday) 68 67				10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.P.A.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) California	
13. FATHER'S NAME Frank				14. MOTHER'S MAIDEN NAME Golding	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 212-20-6779		17. INFORMANT Walter L. Lowman 109 West St., Forest Park Georgia	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 2509 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-respiratory arrest (B) Ac. Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: pneumonia Rt. base (C) Diabetes mellitus, A. S. C. V. D.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/24/68 19 to 9.10.1968, that (I) (we) lost saw the deceased alive on 9.10.1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mohammed Sidig				23B. DATE SIGNED 9.10.68	
23C. PHYSICIAN'S NAME (Type) MOHAMMAD SIDIG MD				23D. ADDRESS	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE Sep 16, 1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Frank W Seitz 814 W 36th St	

12 May 1962

12 May 1962

20

12 May 1962

12 May 1962

12 May 1962

12 May 1962

12 May 1962

12 May 1962

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9396

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JANET ROCKWELL FENN

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month Day Year

9 11 68

Hour

5:50 a M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

200 blk. Overhill Rd. D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 11, 1968 5:50 a M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

6. SEX

Female

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

April 11, 1933

10. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

4431 Wickford Rd.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. E 910.19

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Drowning

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Creek

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

200 blk. Overhill Rd. (Stoney Run Creek)

22D. TIME (Month) (Day) (Year) (Appr.)
OF INJURY (APPROX.)

9 10 68 7 P.m.

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Swept into creek by on coming waters.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

9-12-68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1968

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

82-517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9397

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VERNETTE SHIPLEY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> August 16, 1968 7:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Franklin Square Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 16, 1968 7:10 P.M.	
6. SEX female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-13	
7. RACE negro		C. CITY OR TOWN Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. IN DECEASED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH NOV 11, 1949		E. STREET AND NUMBER 2468 Shirley Avenue	
10. AGE (In years last birthday) 18			
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD SHIPLEY SR.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		15. MOTHER'S MAIDEN NAME BEATRICE BATES	
14B. KIND OF BUSINESS OR INDUSTRY			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. —	
18. INFORMANT DOROTHY LIGGINS		ADDRESS 2468 Shirley Avenue	
19. 642.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA COMPLICATING SEPTIC		CAUSE OF DEATH (A) IMMEDIATE CAUSE UNKNOWN Abortion	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) —	
20. DATE OF OPERATION 8-17-68		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2468 Shirley Avenue			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) UNK		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Abortion possibly criminal			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/17/68			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG 21, 1968	
24C. NAME OF CEMETERY or CREMATORY PINE LAWN MEM. PL.		24D. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Spitz	
25C. FUNERAL DIRECTOR DONALD E. GLOVER		ADDRESS 170 N. PATTER	

الذبحه

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9398

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) HELEN O'DESSA COX		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 6, 1968 7:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1916 E. Eager Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 6, 1968 7:20 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-04	
9. DATE OF BIRTH SEPT 28 1926		10. AGE (In years last birthday) 41 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BALTO MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 220246588	
18. INFORMANT CHARLES COX		ADDRESS 1916 E. EAGER	
19. 796.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 293.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Undetermined DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? 1916 E. Eager St. 2nd floor bedroom		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9 6 68 7:00pm	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? 20xe	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 7, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/16/68	
24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEMORIAL		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR DONALD E. BLAUER		ADDRESS 201 N. PATTERSON PARK AVE	

2597 2180
BATO Maryland 12A

10/1/80
10/1/80

51-64-18

1

B-650

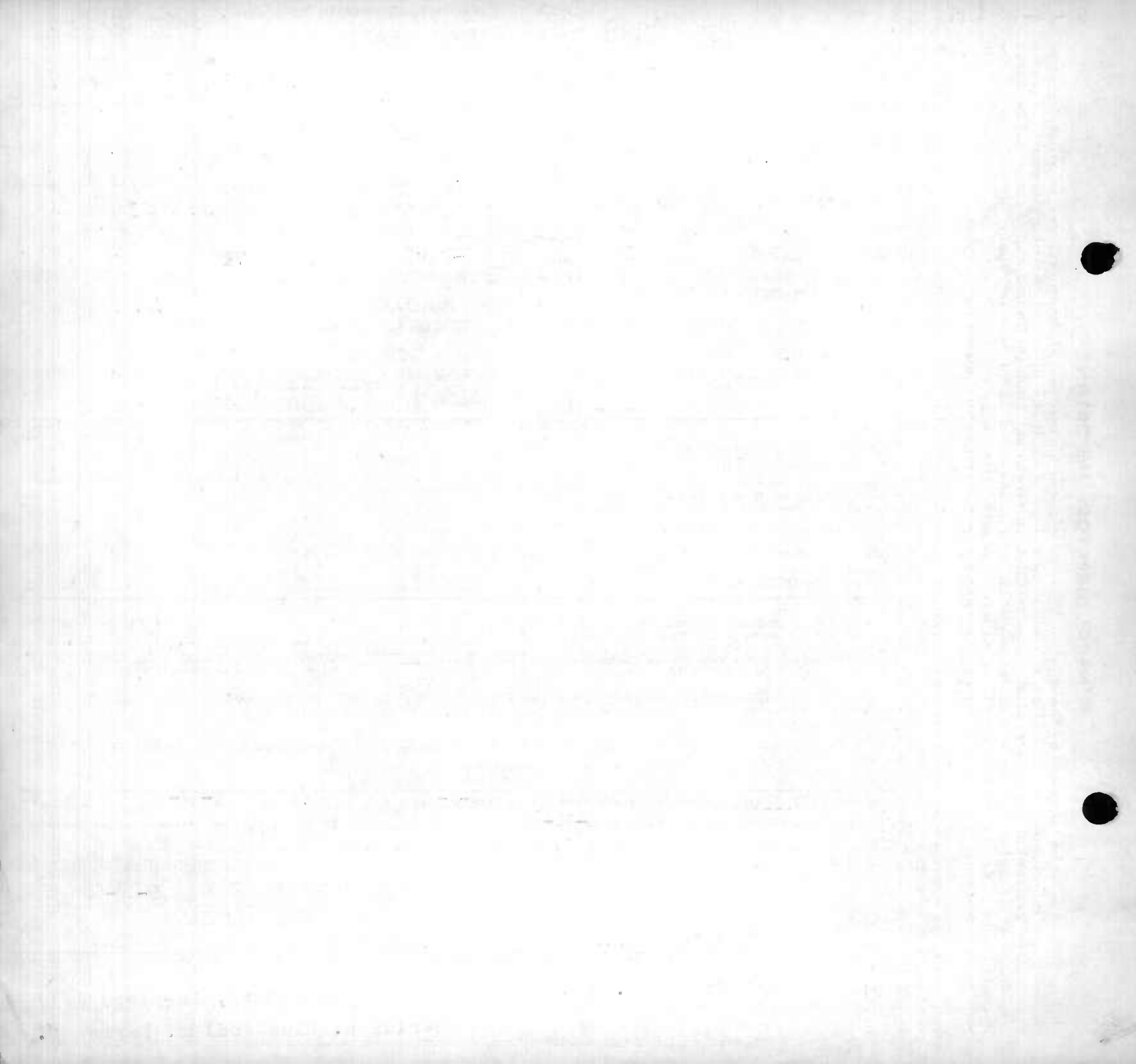
BALTIMORE CITY HEALTH DEPARTMENT
68- 9399 CERTIFICATE OF DEATH

REG. NO. 68- 9399

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ida Brown</i>		2. DATE AND HOUR OF DEATH <i>9/12/68</i> <i>9:00 P.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITAL</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND 21224</i>		E. STREET AND NUMBER <i>2005 WEST SARATOGA STREET 21223</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-27-97</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>BARNES</i>		14. MOTHER'S MAIDEN NAME <i>CORNISH</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-01-7504</i>		17. INFORMANT <i>BALTIMORE CITY HOSPITAL RECORDS</i> <i>4940 EASTERN AVENUE</i> <i>#21224</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Sep. Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Multiple CVA's</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>ASCUD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <i>422.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<i>Anemia</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>YES</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>5-3-</i> <i>19 68</i> to <i>9-12-</i> <i>19 68</i> , that (I) (we) lost saw the deceased alive on <i>9-12-68</i> <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul H. Kalkut, M.D.</i>		23B. DATE SIGNED <i>9-12-68</i>		23C. PHYSICIAN'S NAME (Type) <i>PAUL KALKUT M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/17/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. FUNERAL DIRECTOR <i>Charles A. Rice</i>		24F. ADDRESS <i>661 W. Barre St.</i>	



68- 9400

CERTIFICATE OF DEATH

REG. NO.

68- 9400

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ETHEL CHASE

2. DATE AND HOUR OF DEATH

SEPT. 14, 1968 8:12 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

THE UNION MEMORIAL HOSPITAL

44

4. USUAL RESIDENCE (Where deceased lives. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4442 WRENWOOD AVE.

5. SEX

Female

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

7-17-79

9. AGE (In years
lost birthday)

89 yrs.

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

EMERSON James

14. MOTHER'S MAIDEN NAME

ELLEN COOPER

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ETHEL M. NEWMAN

ADDRESS

4442 WRENWOOD AVE.

18.

412.4 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

A. IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

STARVATION

B.

DUE TO, OR AS A CONSEQUENCE OF:

CEREBRO-VASCULAR ACCIDENT

C.

ASCVD

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

One MONTH

C.S.

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept. 14 1968 to Sept. 14 1968.
that (I) (we) last saw the deceased alive on Sept. 14 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Print)

ANTIONA O. CHAN

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

9-18-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION

(City, town, or county)

Brooklyn, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1968

25B. NAME OF REGISTRAR

R. B. E. F. F. F.

25C. FUNERAL DIRECTOR

R. B. E. F. F. F. 661 W. Barrington

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

444-123456789

F-11-44 847

Final Report
None

Final Report

Final Report

General Research Report

21 Sept 1944

21 Sept 1944

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

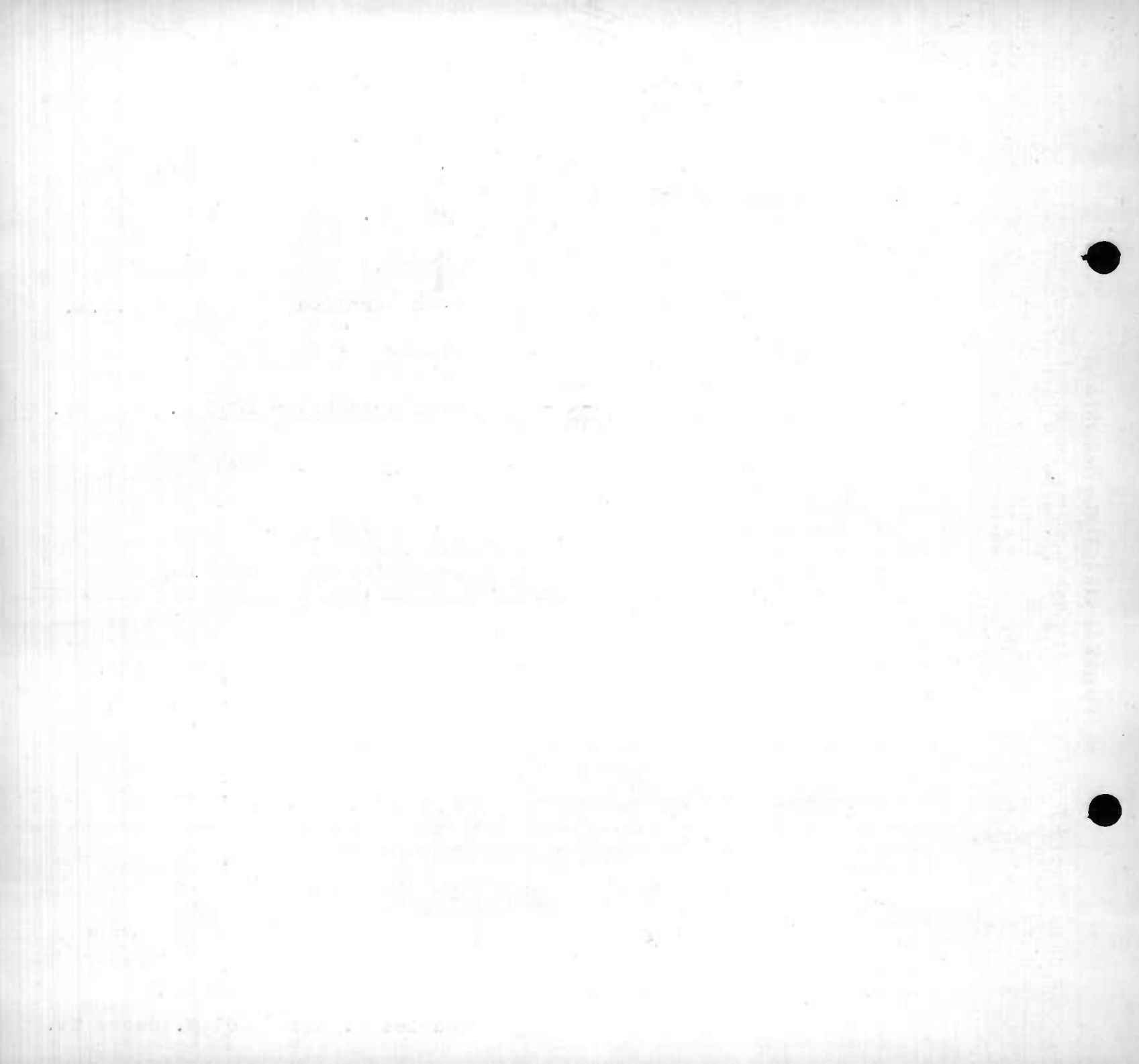
68- 9401 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9401

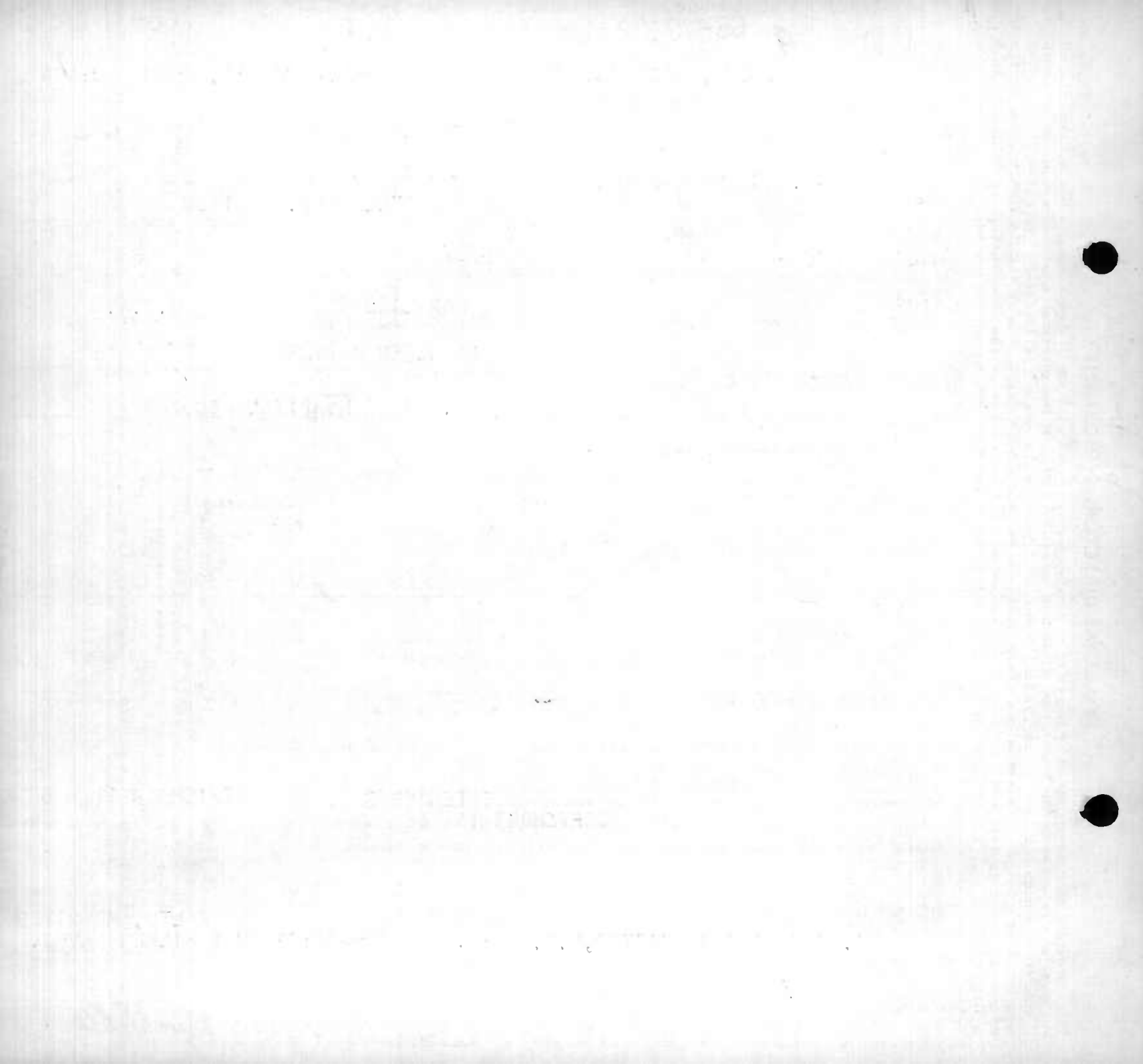
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Theodore Roosevelt McCarter		9/12/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital				A. STATE Maryland	
				B. COUNTY	
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1006 S. Paca Street	
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/02	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 65 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
				11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Andrew McCarter				14. MOTHER'S MAIDEN NAME Lizzie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-6814		17. INFORMANT Novella McCarter 1006 S. Paca St.	
18. 404X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Respiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive & Atherosclerotic DUE TO, OR AS A CONSEQUENCE OF: Coronary Vascular/renal disease (C) _____					
18. 442X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1950 to Sept 12 1968, that (I) (we) last saw the deceased alive on August 20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Borofsky				23B. DATE SIGNED 9/13/68	
23C. PHYSICIAN'S NAME (Type) S Borofsky				23D. ADDRESS 601 N. Howard St. Baltimore 17 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/68		24C. NAME OF CEMETERY or CREMATORY Wayman Cemetery	
24D. LOCATION Maryland		24E. ADDRESS 661 W. Barre St.			
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Charles A. Rice	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9402	
BIRTH NO. 68-17169		68-9402 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MATTHEWS, BABY BOY (B)		2. DATE AND HOUR OF DEATH SEPTEMBER 11, 1968 8:45A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 53-00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 409 OELLA AVE. 21228			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/68	9. AGE (In years last birthday)	If Under 1 Yr. Months: 3 Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME KATHLEEN MATTHEWS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. 776.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac dilatation w/o failure, mild atelectasis of R lung (B) DUE TO, OR AS A CONSEQUENCE OF: Prematurity (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 8 19 68 to SEPTEMBER 11 19 68, that (I) (we) last saw the deceased alive on SEPTEMBER 11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. DeCastro - almon		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) MA. JOSEFINA DE CASTRO, M.D.		23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/68		24C. NAME OF CEMETERY or CREMATORY Oella Cem.	
24D. LOCATION Oella, Md.					
25A. DATE RECEIVED BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barrer	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9403

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 9403

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE E. PORTER

2. DATE AND HOUR OF DEATH

9/14/68 2:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

VIRGINIA

V-43

C. CITY OR TOWN

SMITHFIELD

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

222 ASTARD STREET

5. SEX

F

6. RACE

N

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2-7-01

9. AGE (In years lost birthday)

67

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Smithfield Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S. A.

13. FATHER'S NAME

Edward Johnson

14. MOTHER'S MAIDEN NAME

Luz Thomas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

From chart.

18. 43101

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral hemorrhage & left hemiplegia

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/9/1968 to 9/14/1968, that (I) (we) lost saw the deceased alive on 9/14/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David Khoo

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

DAVID KHOO

DEGREE

23D. ADDRESS

LUTHERAN HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

9/17/68

Henry Tynes Memorial Cemetery- Smithfield Virginia

25A. DATE RECEIVED BY HEALTH DEPT.

25B. NAME OF REGISTRAR

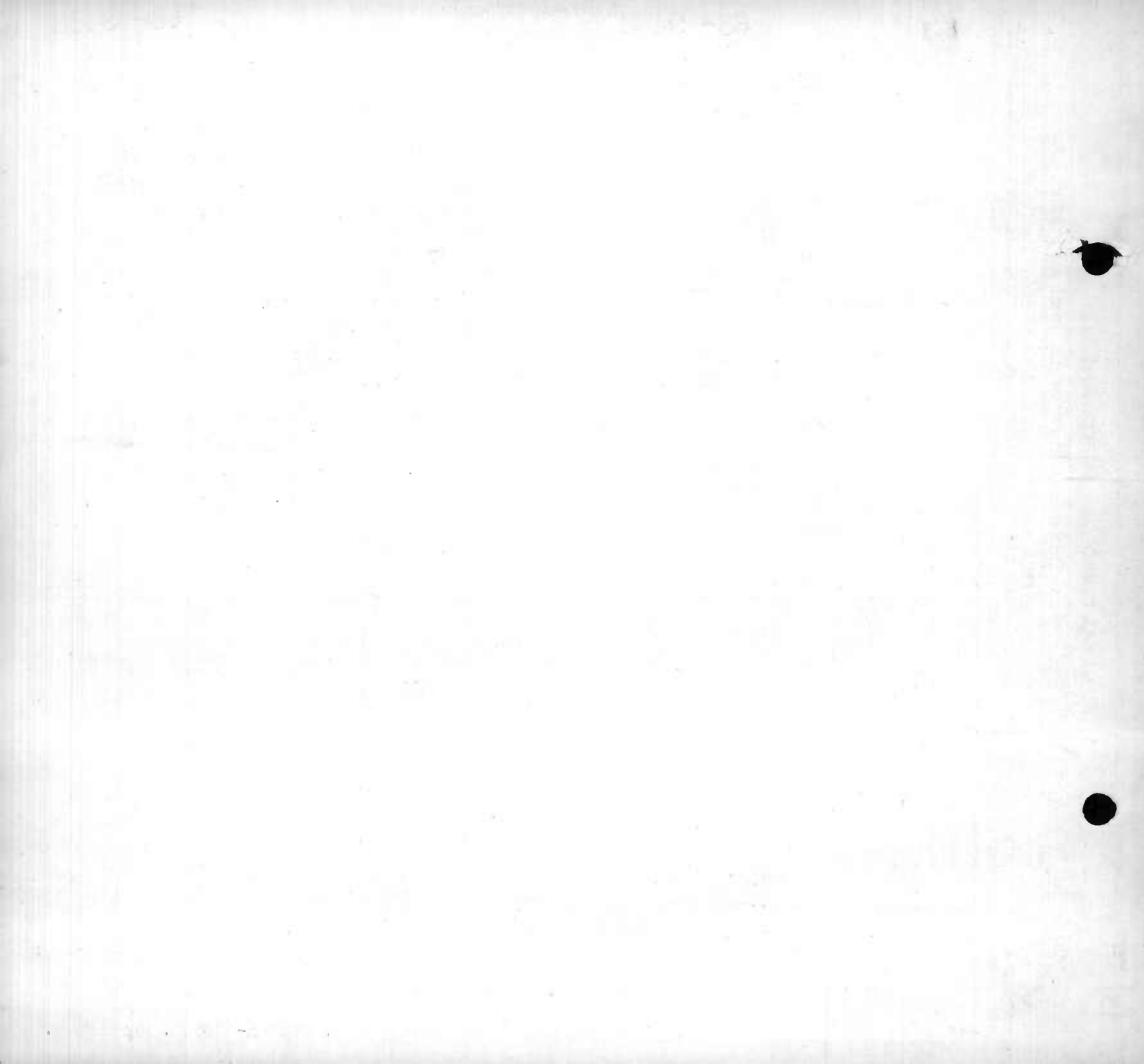
25C. FUNERAL DIRECTOR

ADDRESS

SEP 16 1968

Robert E. Jackson

Herbert E. Nutter-3035 W. North Ave.



FUNERAL DIRECTOR: IMPORTANT

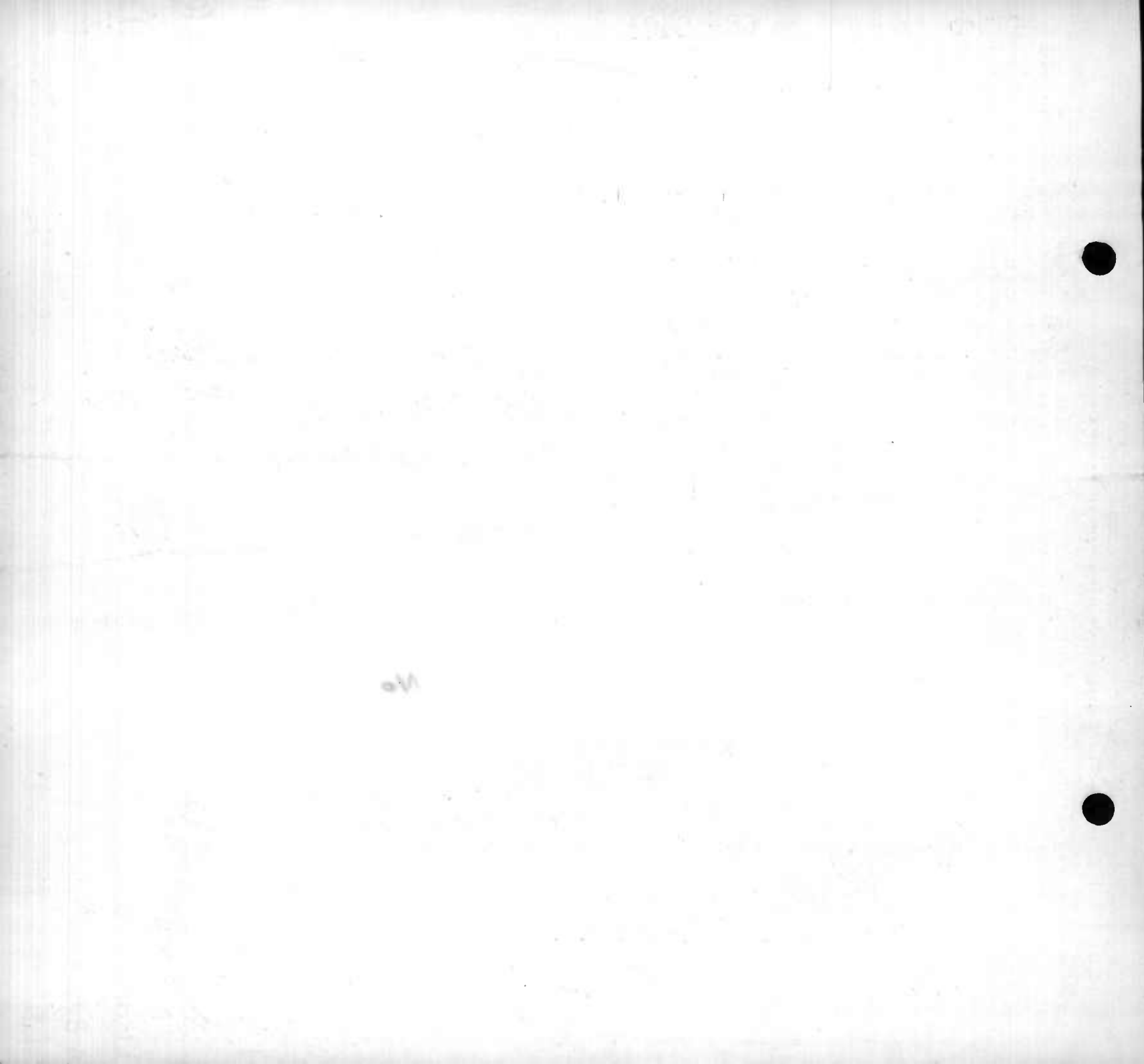
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9404 CERTIFICATE OF DEATH

REG. NO.

68- 9404

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PRINCE DEAN		2. DATE AND HOUR OF DEATH Sept. 15, 1968 6:46 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1326 N. LUZERNE AVE	
5. SEX MALE	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/07	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME JACK DEAN		14. MOTHER'S MAIDEN NAME Isabelle Eastland			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 266099829		17. INFORMANT ADDRESS Mildred Dean 1326 N. LUZERNE	
18. 4-12-4-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRAIN STEM VASCULAR ACCIDENT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		(B) 15 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 4 22.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/4 19 68 to 9/15 19 68 , that (I) (we) last saw the deceased alive on 9/15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Rosenbaum, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept 15, 1968	
23C. PHYSICIAN'S NAME (Type) ROBERT A. ROSENBAUM, M.D.		23D. ADDRESS JHH			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/18/68		24C. NAME OF CEMETERY or CREMATORY St. Catherine's	
24D. LOCATION (City, town, or county) (State) D. D. County, Md.		25A. DATE RECEIVED SEP 16 1968			
25B. NAME OF REGISTRAR Robert E. Fairburn		25C. FUNERAL DIRECTOR Joseph E. Locks		ADDRESS 1304 N. Con...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9405

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR ERIC ANDERSON

2. DATE AND HOUR OF DEATH

Sept. 15, 1968

3²⁰ P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2407 Louise Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒

NO ☐

E. STREET AND NUMBER

2407 Louise Ave.

5. SEX

male

6. RACE

caucasian

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Aug. 14, 1908

9. AGE (In years
last birthday)

60

If Under 1 Yr.
Months: Days

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

guard

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Social Security

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joel Anderson

14. MOTHER'S MAIDEN NAME

Hulda Larson

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WWII

16. SOCIAL
SECURITY NO.

060-05-3686

17. INFORMANT

Mrs. Ruth Anderson, 2407 Louise Ave.

ADDRESS

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of lung

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

163X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Bronchopneumonia

3 mos.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1, 1968 to Sept 15, 1968,
that (I) (we) last saw the deceased alive on Sept 13, 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

Wm Carl Ebeling MD

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

9-16-68

23C. PHYSICIAN'S
NAME (Type)

Dr.

Ebeling

23D. ADDRESS

701 St. Paul St, Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

burial

24B. DATE

9-18-68

24C. NAME OF CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1968

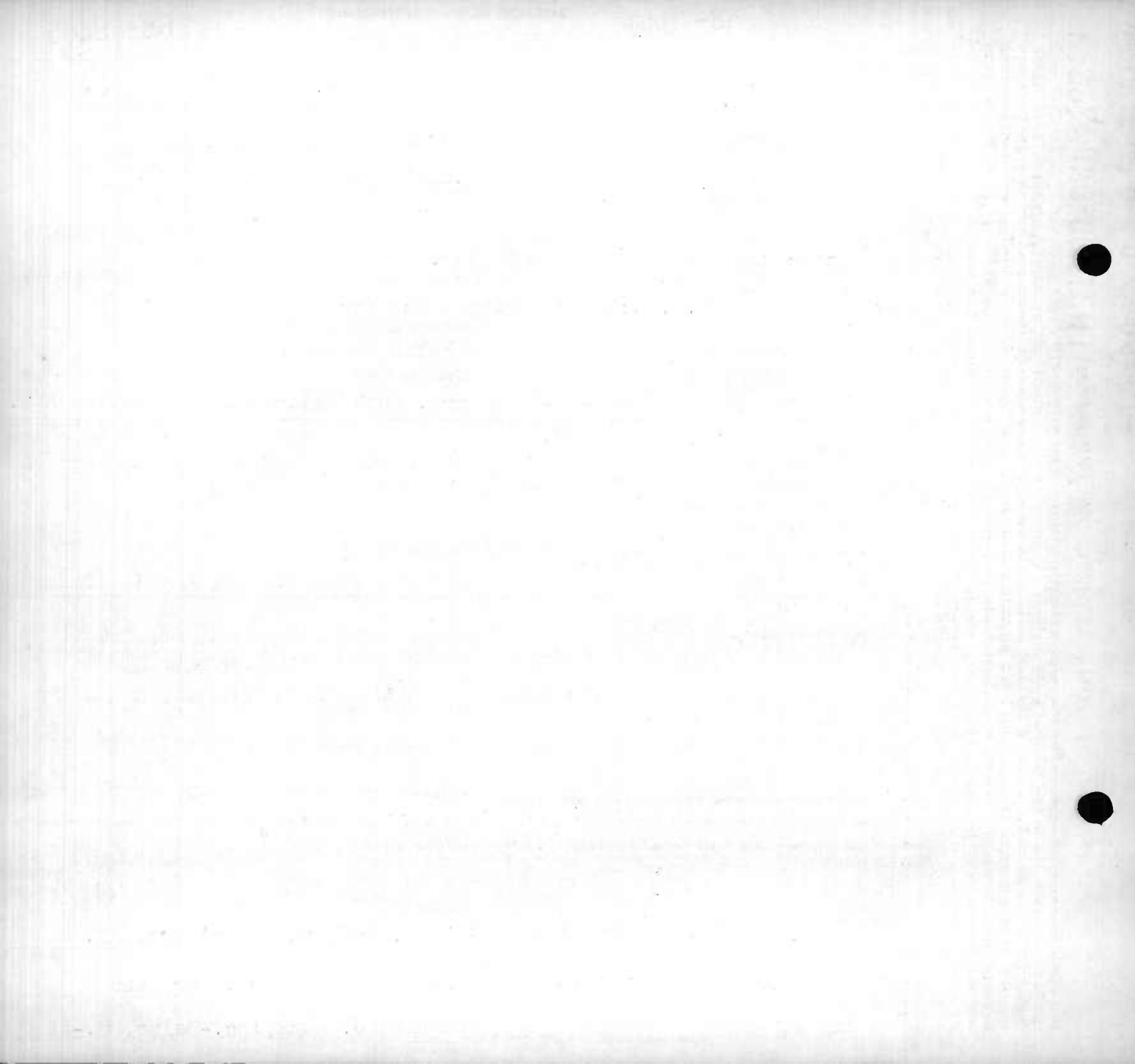
25B. NAME OF REGISTRAR

Robert J. Taylor

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc.-Balto, Md.-14

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9406 CERTIFICATE OF DEATH

REG. NO. 68- 9406

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM J. GRAHAM		2. DATE AND HOUR OF DEATH September 13, 1968 10²² P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 THE UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 3300 AILSA C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3300 AILSA AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/88 89.	9. AGE (In years last birthday) 80 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME Charles E. Graham		14. MOTHER'S MAIDEN NAME Emma Song	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-46-3079		17. INFORMANT Mrs. Regina A. Graham THE CHART	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) Anteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH About 18 months			
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from SEPTEMBER 10 19 68 to SEPTEMBER 13 19 68 , that (I) (we) last saw the deceased alive on SEPTEMBER 13 19 68 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (<u>did not</u>) view the body after death.					
23A. SIGNATURE Chun Kee Ryn		M.D. DEGREE CHUN KEE RYN		23B. DATE SIGNED SEPTEMBER 13, 1968	
23C. PHYSICIAN'S NAME (Type) CHUN KEE RYN		M.D. DEGREE		23D. ADDRESS THE UNION MEMORIAL HOSPITAL THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/17/68.		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION Baltimore, Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	
25D. ADDRESS					

WAGE WHITE

X

08/31/88 80

WAGLAND

THE GUEST

Acute Abdominal Infection

Antibiotic Therapy Discontinued

No

SEPTEMBER 12 88

☐

☐

M.D.

M.D.

Chun Lee Kim

(CHUN LEE KIM)

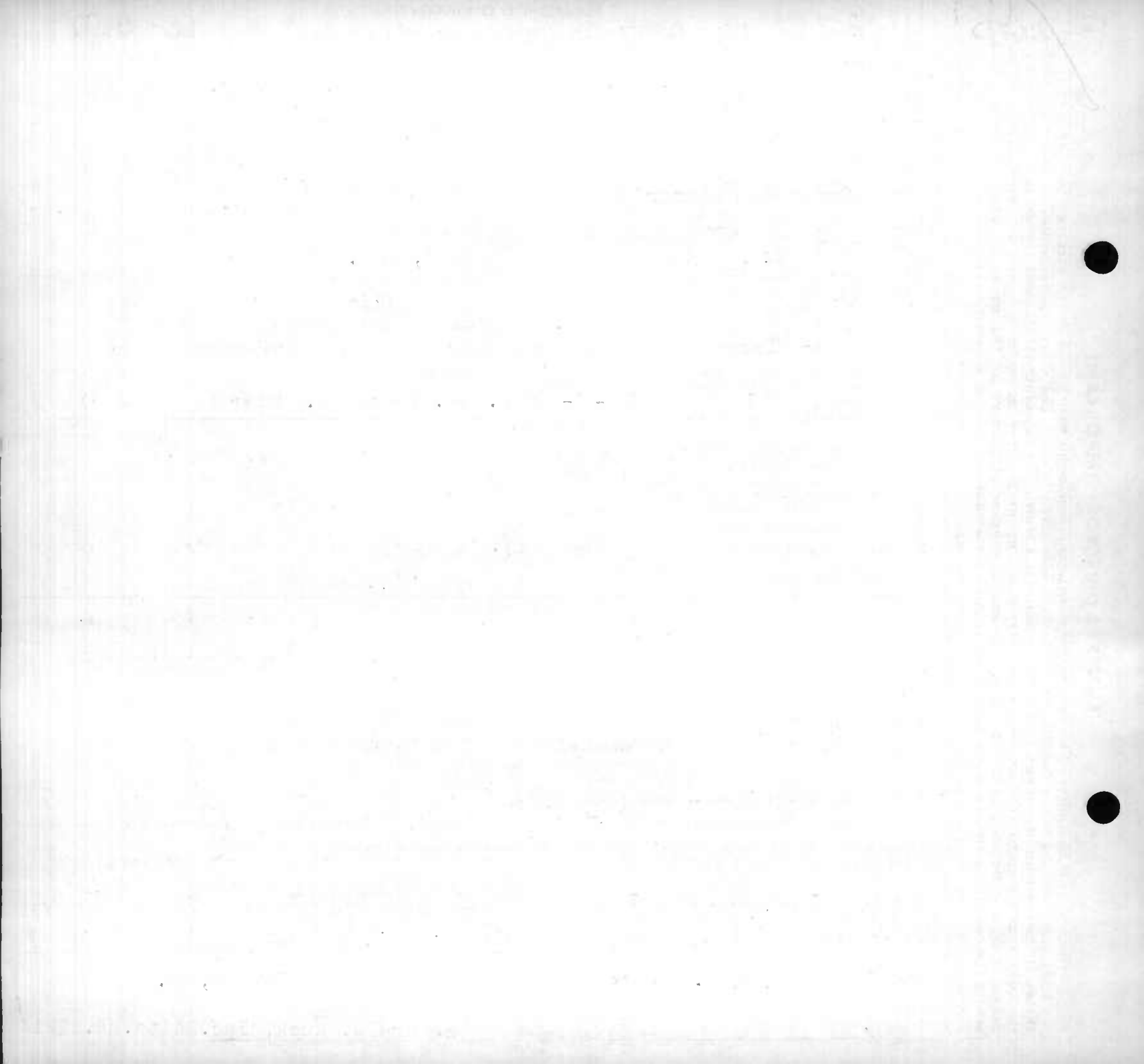
THE UNION MEDICAL HOSPITAL
SEPTEMBER 12 88

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9407 CERTIFICATE OF DEATH

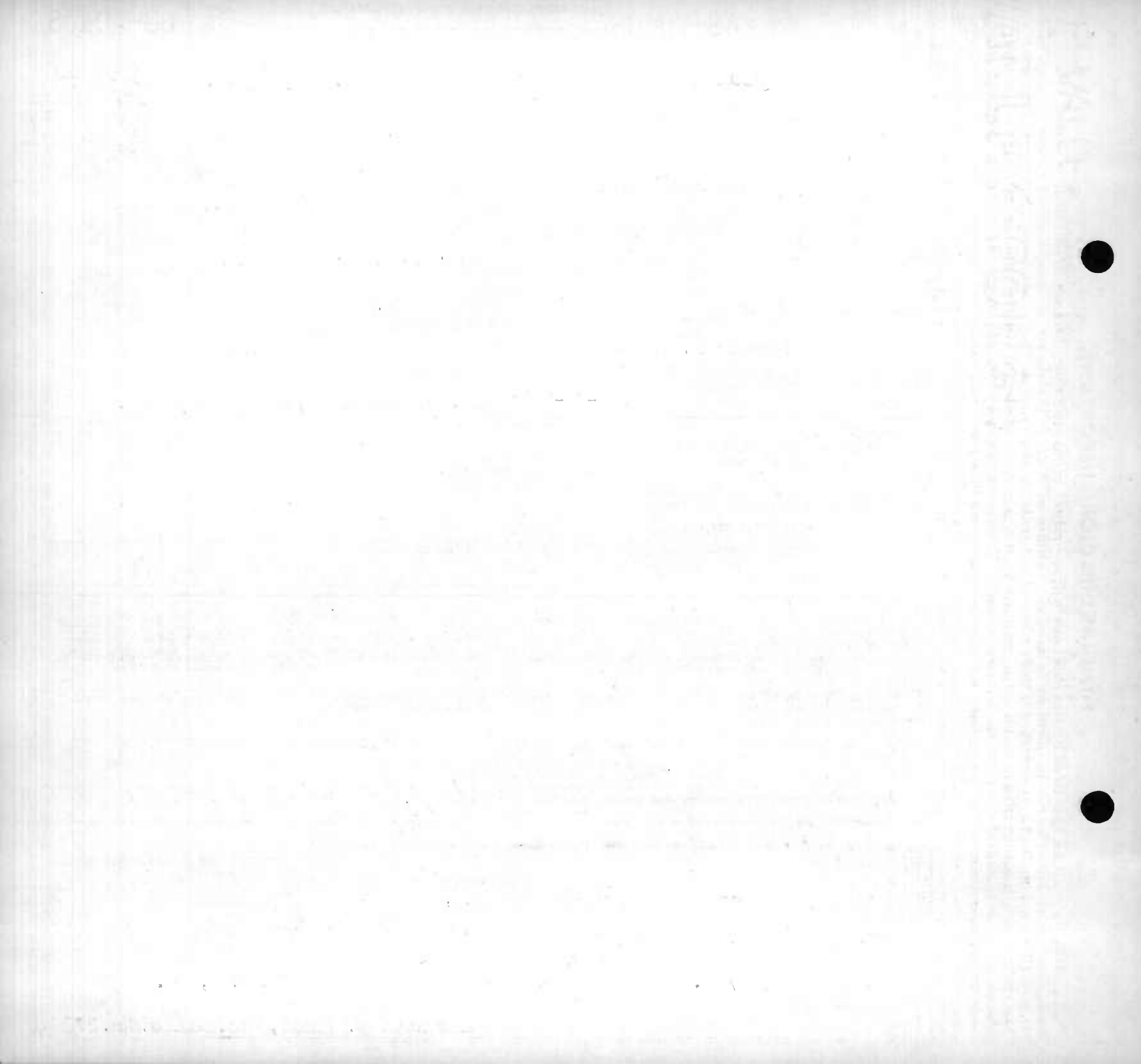
REG. NO. 68- 9407

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Ralph L. Fisher		2. DATE AND HOUR OF DEATH Sept. 14, 1968. 4:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 3, 1892.		9. AGE (In years last birthday) 76		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ome Fisher		14. MOTHER'S MAIDEN NAME Catherine Monohan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 169-03-0477 A.		17. INFORMANT Mrs. Margaret V. Fisher ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.9 I 1. Corneo-sclerotic Heart Disease acute MI & failure 2. (B) Due to (C) AS - consequence of (C) stroke Syndrome 420.1 II S recent Fracture Rt Hip & pinning		19. DATE OF OPERATION 0		20. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 14 July 1968 to Sept 14 1968 and that in (my) (our) opinion death occurred on the date Sept 14 1968 and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Don W. Minter DEGREE		23B. DATE SIGNED 9/16/68	
23C. PHYSICIAN'S NAME (Type) Don W. Minter DEGREE		23D. ADDRESS 3009 EVERGREEN AVE BALTO MD		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 9/17/68.		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. MD. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>George Vincent Hook</i>		2. DATE AND HOUR OF DEATH <i>Sept. 14, 1968. 6:30 P.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4423 Pimlico Road</i>		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS <i>27-16</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>4423 Pimlico Road</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 9, 1908.</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Ice Man</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Thomas S. Hook</i>		
14. MOTHER'S MAIDEN NAME <i>Bertha Miller</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>218-36-5349</i>			17. INFORMANT <i>Mrs. Irene Gray, 3416 Mary Ave.</i>		
18. <i>41231</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE (i) <i>Arterio Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Heart Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Generalized Arterio-Sclerosis</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 7 - 1968</i> to <i>Sept. 14 1968</i> , that (I) last saw the deceased alive on <i>Sept. 7 - 1968</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE <i>Earl L. Chambers, Jr.</i> DEGREE				23B. DATE SIGNED <i>9/16/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Earl L. Chambers -</i> DEGREE				23D. ADDRESS <i>4108 Liberty St. Balto. Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/18/68.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 16 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md.</i>		25D. ADDRESS <i>21214</i>			



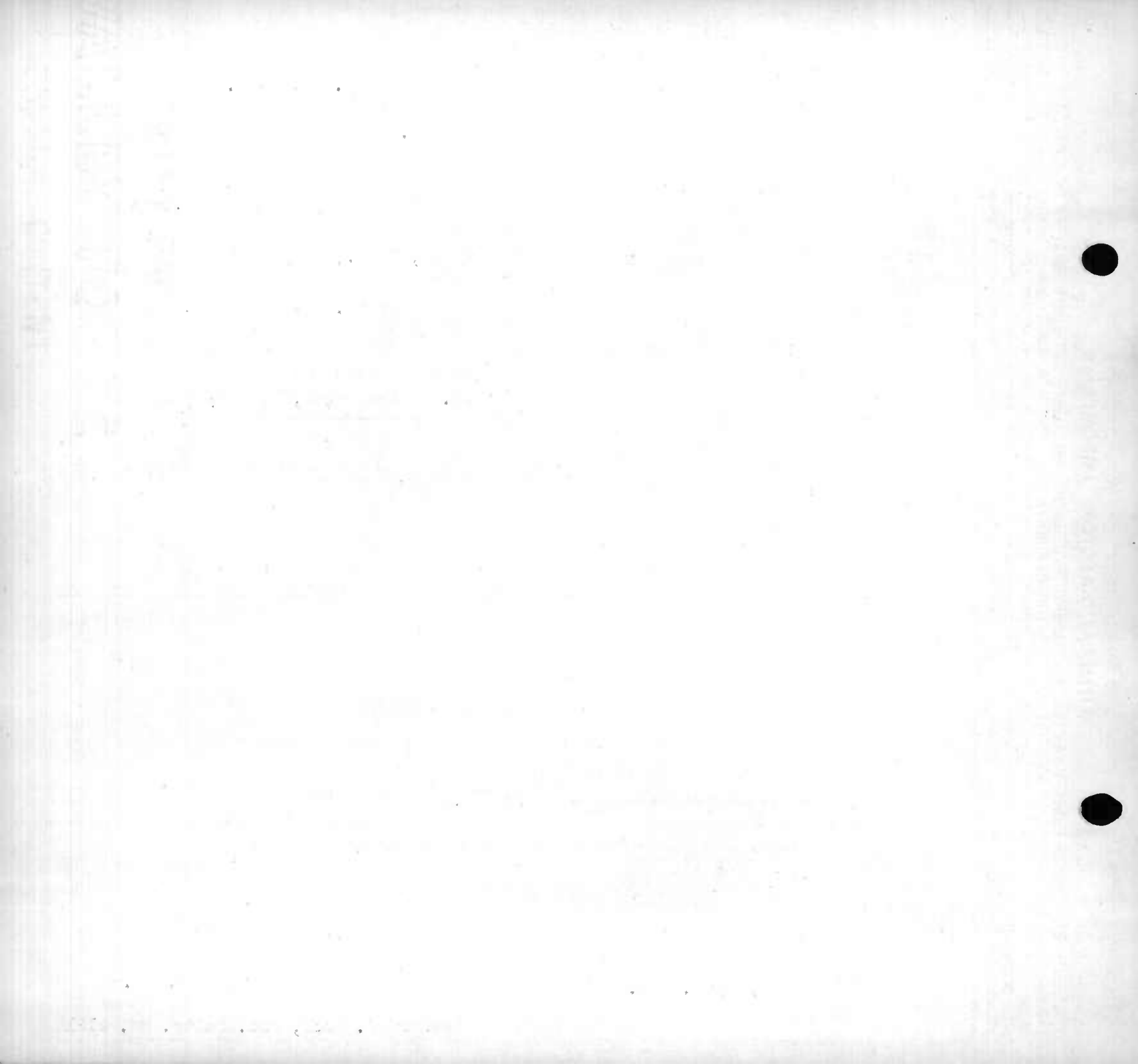
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9409 CERTIFICATE OF DEATH

REG. NO. 68- 9409

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FLORENCE R. DUTROW		Sept. 13, 1968. 530 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 GOULD CONVALESARIUM				A. STATE Md.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5517 Soften Avenue	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1890.	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Robinson		14. MOTHER'S MAIDEN NAME Not Known	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-9438		17. INFORMANT Mrs. Marion Boone, 1714 Edgewood Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) 491X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days.	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 491X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPRDX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-22-1968 to 9-13-1968, that (I) (we) last saw the deceased alive on 9-13-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sebastian Russo				23B. DATE SIGNED 9-14-68	
23C. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO				23D. ADDRESS 5017 Harford Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/68		24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9410
68-9410 CERTIFICATE OF DEATH				
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) LAMB, CHAUNCEY D.		9/13/68 9:20 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL Hospital		A. STATE Maryland B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX M 6. RACE W		E. STREET AND NUMBER 335 E. 25th STREET Baltimore, Md.		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06-30-91 9. AGE (In years lost birthday) 77		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED. Inspector Balto. City		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME JOHN C. LAMB		14. MOTHER'S MAIDEN NAME Ida Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MARGARET BENNET ADDRESS 5902 FENWICK AVENUE
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8/31 19 68 to 9/13 19 68 , that (I) (we) last saw the deceased alive on 9/13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ricardo Mori M.D.		23B. DATE SIGNED 9/13/68		23C. PHYSICIAN'S NAME (Type) RICARDO MORI, M.D.
23D. ADDRESS THE UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-68		24C. NAME OF CEMETERY or CREMATORY Parkwood
24D. LOCATION (City, town, or county) Balto., Md.		24E. (State)		
25A. DATE RECEIVED BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR John E. [unclear]		25C. FUNERAL DIRECTOR J. J. Ruck One, 5305 Harford Rd.
ADDRESS				

Handwritten text, possibly a signature or name, oriented vertically.

Handwritten text, possibly a date or number, oriented vertically.

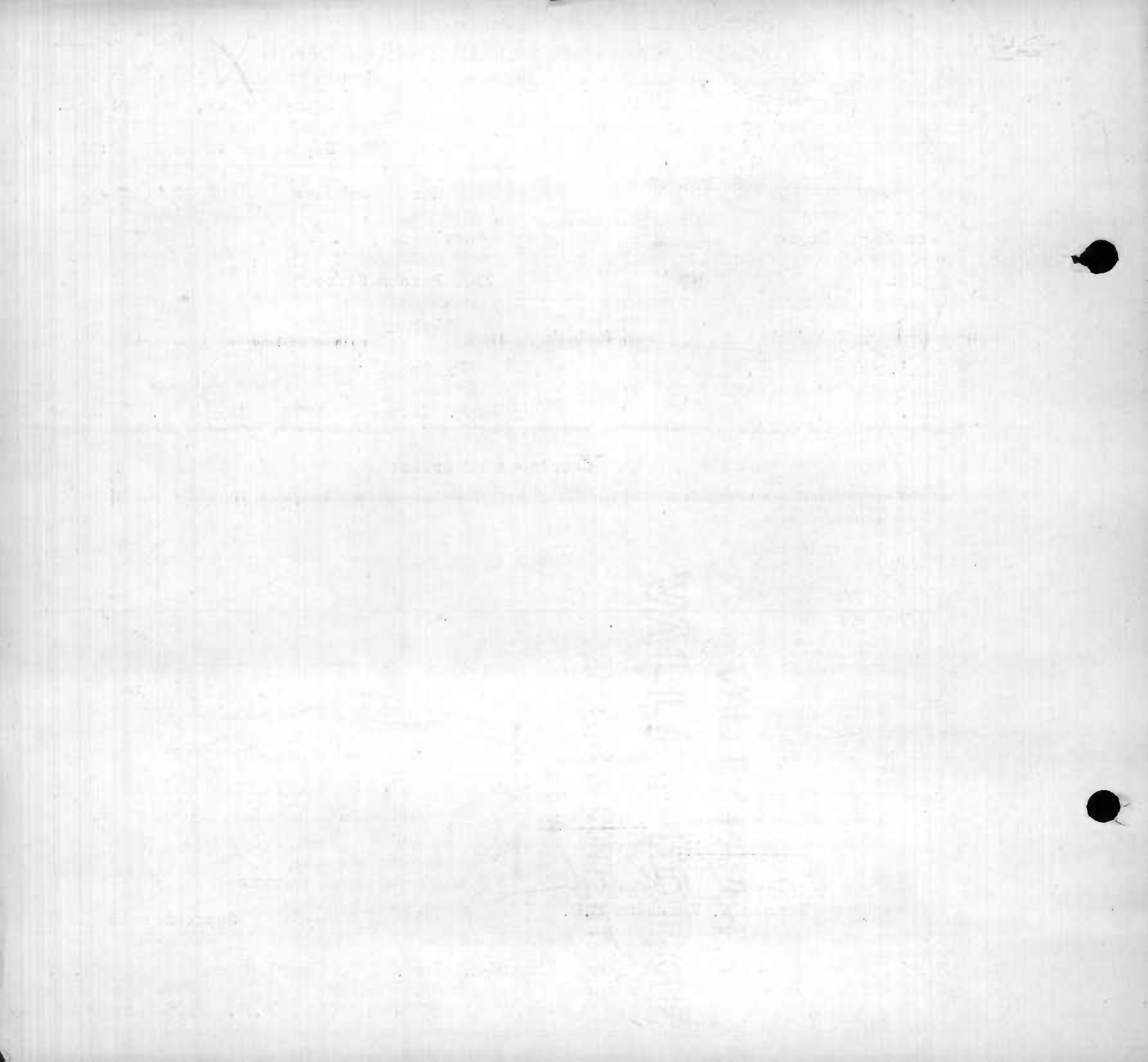
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9411

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MINNIE (Emily) JACKSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 12, 1968 8:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR IN INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 12, 1968 8:20 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Charlotte, N.C.	
9. DATE OF BIRTH 12-9-1920		10. AGE (In years last birthday) 47 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Andrews, S.C.		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Richard White		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitress		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Julia Flager		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Sennie Davis	
19. 174 X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Breast (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED September 13, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-68	
24C. NAME of CEMETERY or CREMATORY York Memorial Cem.		24D. LOCATION (City, town, or county) (State) Charlotte, N.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Ronald E. Fedy	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



1
A-15368- 9412 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9412

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OLIVIA AVENT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 12, 1968 6:15 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2620 Springhill Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour September 12, 1968 6:15 P. M.	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 8-12-1904	10. AGE (In years last birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 2620 Springhill Avenue	
11. BIRTHPLACE (State or foreign country) Rocky Mount, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
15. MOTHER'S MAIDEN NAME Alice Wright		13. FATHER'S NAME Milton Yarboro	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Doreatha Robinson		ADDRESS 2620 Springhill	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 180X + 250.9 CAUSE OF DEATH Carcinoma of Cervix (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION 171X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II Diabetes Mellitus			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED September 13, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-68	
24C. NAME OF CEMETERY or CREMATORY SWIFT CREEK BAPT CH. CEM.		24D. LOCATION (City, town, or county) (State) Whitakers, N.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9413 CERTIFICATE OF DEATH

REG. NO. 68- 9413

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HINTON Mr LEON		2. DATE AND HOUR OF DEATH 13th Sept 68 6:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Church Home and Hospital, Baltimore Maryland.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND BALTO B. COUNTY BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home and Hospital, Baltimore Maryland.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 9-20-68		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-16-43		9. AGE (In years last birthday) 25		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Connie Hinton		14. MOTHER'S MAIDEN NAME ANNIE JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT MRS NEWTON - Phone 9477445	
18. 5-69-9 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest due to anaemia, Electrolyte Imbalance			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: G.I. bleeding (massive)			
(C)					
19. 5-78 X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 19-6-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Resp distress		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-1-1968 to 9-13-1968 , that (I) (we) last saw the deceased alive on 9-13-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mesbah Ud Dowla				23B. DATE SIGNED 9-13-68	
23C. PHYSICIAN'S NAME (Type) MESBAH UD DOWLA, MD				23D. ADDRESS CHURCH HOME AND HOSPITAL, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park Balto.	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR Morton E Dgett F.H. 1701 Laureals	

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

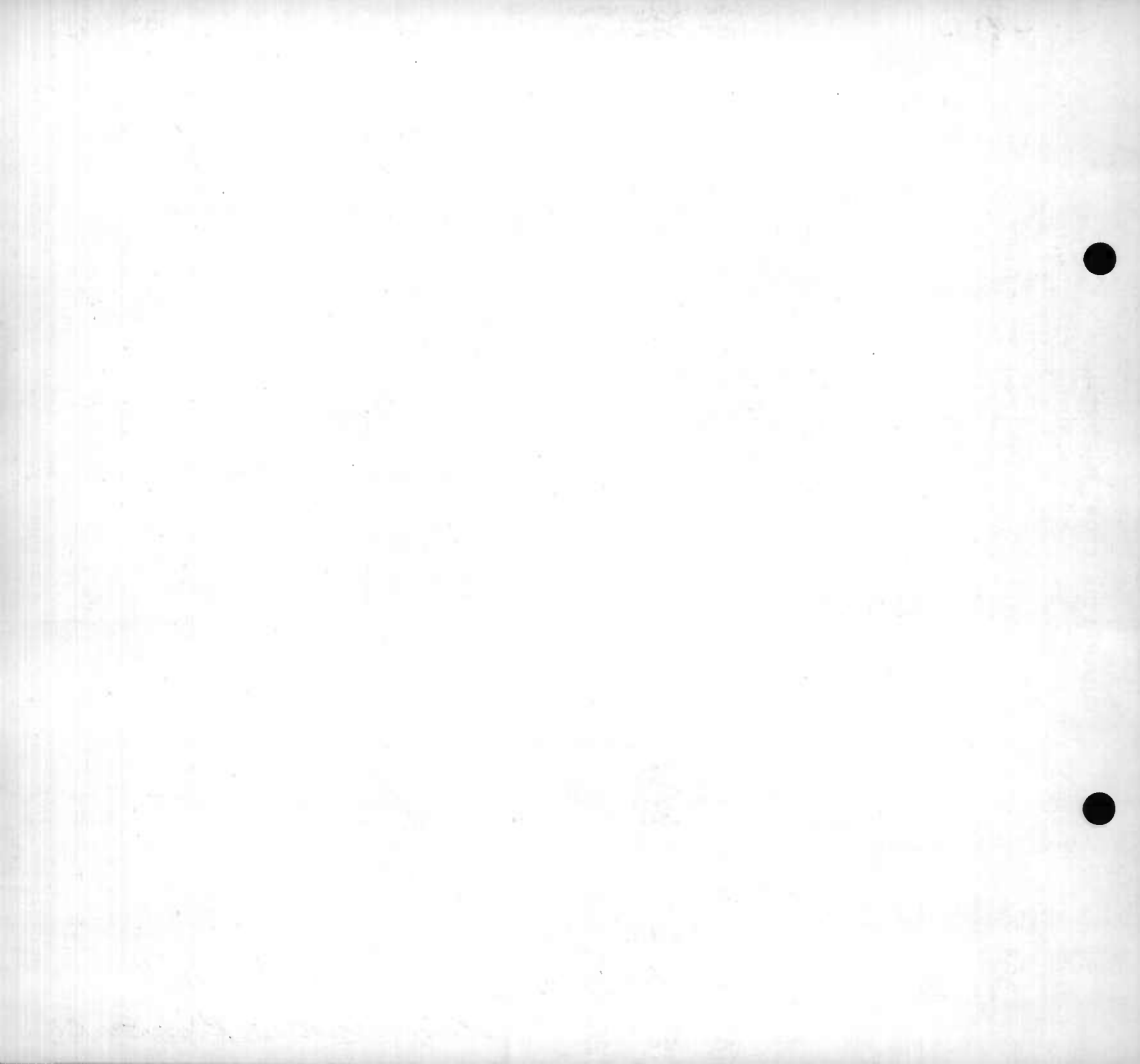
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9414 CERTIFICATE OF DEATH

REG. NO. 68- 9414

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Kess George Lafayette</u>		2. DATE AND HOUR OF DEATH <u>9/14/68</u> <u>4:15</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>AA</u>		5. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hspt.</u>		E. STREET AND NUMBER <u>7321 Watson Lane</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <u>M</u>	7. RACE <u>C</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <u>1/17/25</u>	10. AGE (In years last birthday) <u>43</u>	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Monky, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George M. Kess</u>		14. MOTHER'S MARDEN NAME <u>Irene Brooks</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-6919</u>		17. INFORMANT <u>Lille Kess</u>	
ADDRESS <u>Same</u>		18. <u>746.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> (B) <u>A-V. communi (congenital)</u> (C) <u>heart disease</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>75-4.5 II</u>			
19A. DATE OF OPERATION <u>9/12/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>A.V. communi</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/14/1968</u> to <u>9/14/1968</u> , that (I) (we) last saw the deceased alive on <u>9/14/1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. M. Juanteguy</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/13/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. M. Juanteguy</u>		23D. ADDRESS <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-18-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>White Mount Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Same Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 18 1968</u>		25B. NAME OF REGISTRAR <u>Ed. J. Johnson</u>	
25C. FUNERAL DIRECTOR <u>Elis. Dickerson</u>		25D. ADDRESS <u>Brimley Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		2. DATE AND HOUR OF DEATH 13 th Sept 1968 4:10 A.M.	
1. NAME OF DECEASED (Type or Print) FORD, Mrs Carrie Mabel			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND - BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home and Hospital Baltimore Maryland 21231		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1616 E. LOHARD Street.	
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-01-11
		9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10B. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) VA. USA.		12. CITIZEN OF WHAT COUNTRY? AMER	
13. FATHER'S NAME MOSE SNEAD		14. MOTHER'S MAIDEN NAME MATTIE BANKS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT V. GANGADHARAN. M.D	
		ADDRESS 100 N Broadway Balto MD.	
18. 39601		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR FIBRILLATION Rheumatic Heart Disease - Aortic and Mitral Valvular disease (B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure. (C) Habnnd nitins	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes years months			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 13th Sept 68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED For adequate airway + toilet	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12th Sept 1968 to 13th Sept 1968 that (I) (we) last saw the deceased alive on 13th Sept 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED 13th Sept 1968	
23C. PHYSICIAN'S NAME (Type) A. E. SUBONG, JR		23D. ADDRESS 100 N. BROADWAY. BALTO MD 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-17-68	
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Henry O. Watson		ADDRESS 1000 Brantley Ave	

MATTIE BARKS

MORE SUCAS

WILLIAM B. BARKS

WILLIAM B. BARKS
WILLIAM B. BARKS
WILLIAM B. BARKS
WILLIAM B. BARKS
WILLIAM B. BARKS

WILLIAM B. BARKS

WILLIAM B. BARKS

WILLIAM B. BARKS

WILLIAM B. BARKS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 9416		REG. NO. 68- 9416	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Mary Foster		2. DATE AND HOUR OF DEATH 8:30 PM 9/14/68 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 1436 N. BOND ST.			
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-6-90	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GABRIEL JOHNSON				14. MOTHER'S MAIDEN NAME EMILY Benkey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Severe hypertensive arteriosclerotic ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardiovascular disease				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II							
19A. DATE OF OPERATION 9/14/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/7/68 1968 to 9/14 1968 , that (I) (we) last saw the deceased alive on 9/14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David A. Bass				23B. DATE SIGNED 9/14/68		23C. PHYSICIAN'S NAME (Type) DAVID A. BASS	
23D. ADDRESS JOHNS HOPKINS HOSP							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-1968		24C. NAME of CEMETERY or CREMATORY Notobay Court		24D. LOCATION (City, town, or county) (State) Brooklyn Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Clayton Wilson		25D. ADDRESS 1011 Brantley Rd	

Don't forget to bring your

check with you

10

10

10

10

10

Don't forget to bring your

check with you

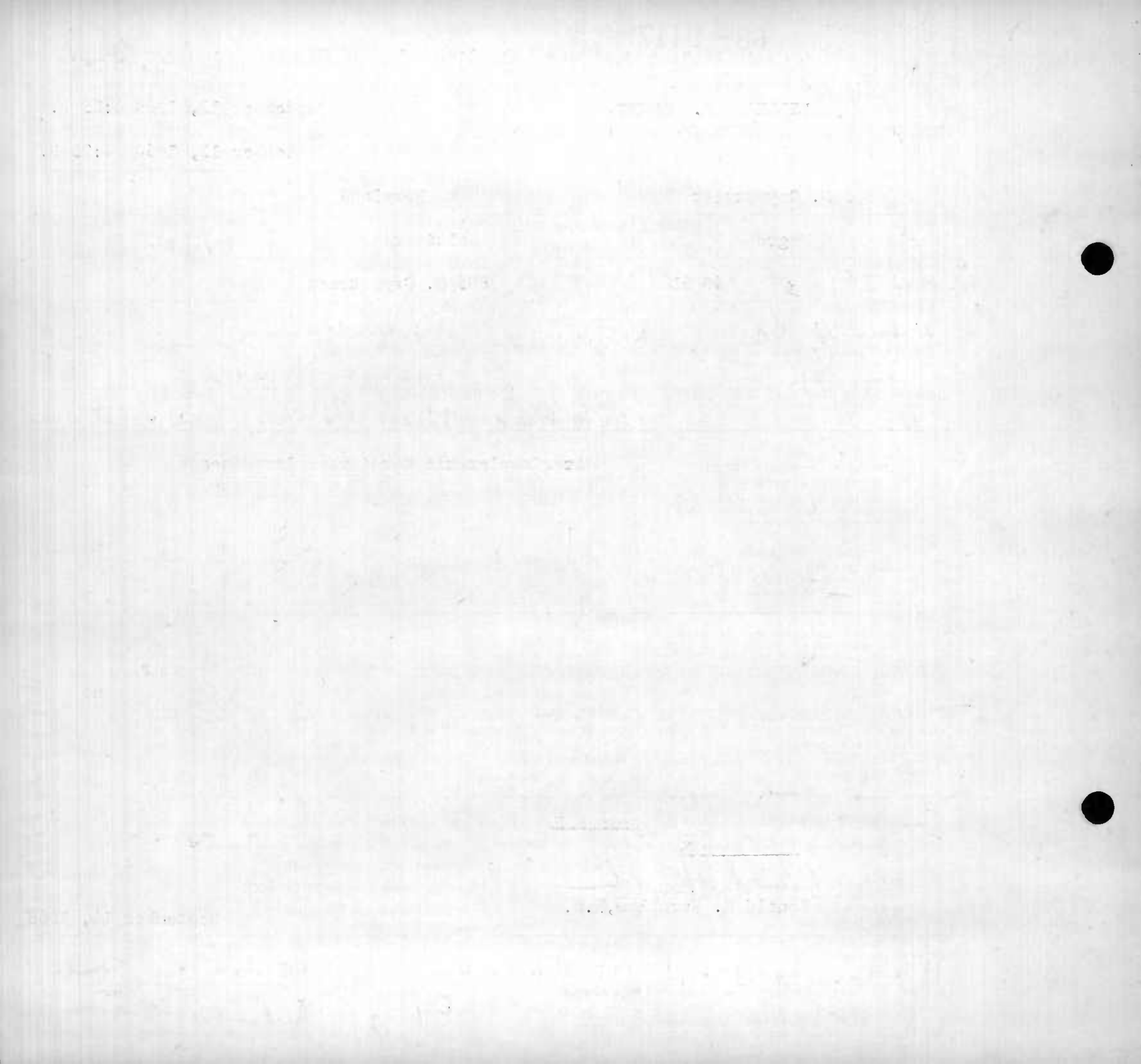
Don't forget to bring your

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9417

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LILLIAN H. BANKS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 13, 1968 4:25 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 805 N. Gay Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 13, 1968 4:25 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Mar 6 1902		10. AGE (In years lost birthday) 66 61 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Nelson Co. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Howard		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Ernie Howard		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 217-124-460A		18. INFORMANT Mrs. Brook	
19. CAUSE OF DEATH 412.4.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Atherosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH no	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 14, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-18-68	
24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1968		25B. NAME OF REGISTRAR Paul E. Taylor, M.D.	
25C. FUNERAL DIRECTOR E. Henry W. Wilson		ADDRESS 100-Baltimore Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9418 CERTIFICATE OF DEATH

REG. NO. 68- 9418

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Horton, Mildred</i>		2. DATE AND HOUR OF DEATH <i>Sept. 13, 1968 4 P</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>X</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE John Hopkins Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. RESIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>300 B DALLAS CT.</i>		5. SEX <i>Female</i>		6. RACE <i>Negro</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-19-22</i>		9. AGE (In years last birthday) <i>45</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wilson, W</i>	
13. FATHER'S NAME <i>CHARLIE WHITLEY</i>		14. MOTHER'S MAIDEN NAME <i>MERTIE ROSS</i>		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sedney Horton</i>	
18. <i>180X-125019</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac Failure</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>171X II</i>		(B) <i>Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>1966</i>	
		(C) <i>Carcinoma of Cervix IC. I. B</i>		<i>1963</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Diabetes mellitus</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>August 26 1968</i> to <i>September 13 1968</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>September 13 1968</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lawrence R. Donahue MD</i>				23B. DATE SIGNED <i>13 September 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>XXXX LAWRENCE DONAHUE M.D.</i>				23D. ADDRESS <i>601 North Broadway Baltimore Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>9-18-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>White Mt Cal</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>Elroy Wilson</i>		25D. ADDRESS <i>1020 Pennsylvania Ave</i>			

1914

Caroline F. Jones

Caroline F. Jones

Caroline F. Jones

Diabetes mellitus

No.

August 20 1914

September 12 1914

XXXX L

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9419

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) STANLEY OGLESBY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> August 15, 1968 UNK M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 122 Ropewalk Lane		3. DATE PRONOUNCED DEAD Month Day Year Hour August 16, 1968 5:30 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 60		C. CITY OR TOWN Baltimore	
11. BIRTHPLACE (State or foreign country) Ind		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 122 Ropewalk Lane	
13. FATHER'S NAME Lin		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Lin		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Gertude Newman Montgomery 125 W ADDRESS	
19. 412.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/17/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/68	
24C. NAME OF CEMETERY or CREMATORY McCalvary		24D. LOCATION (City, town, or county) (State) Chesapeake	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR W. W. Montgomery		25D. ADDRESS 108	

WILLIAM FORD

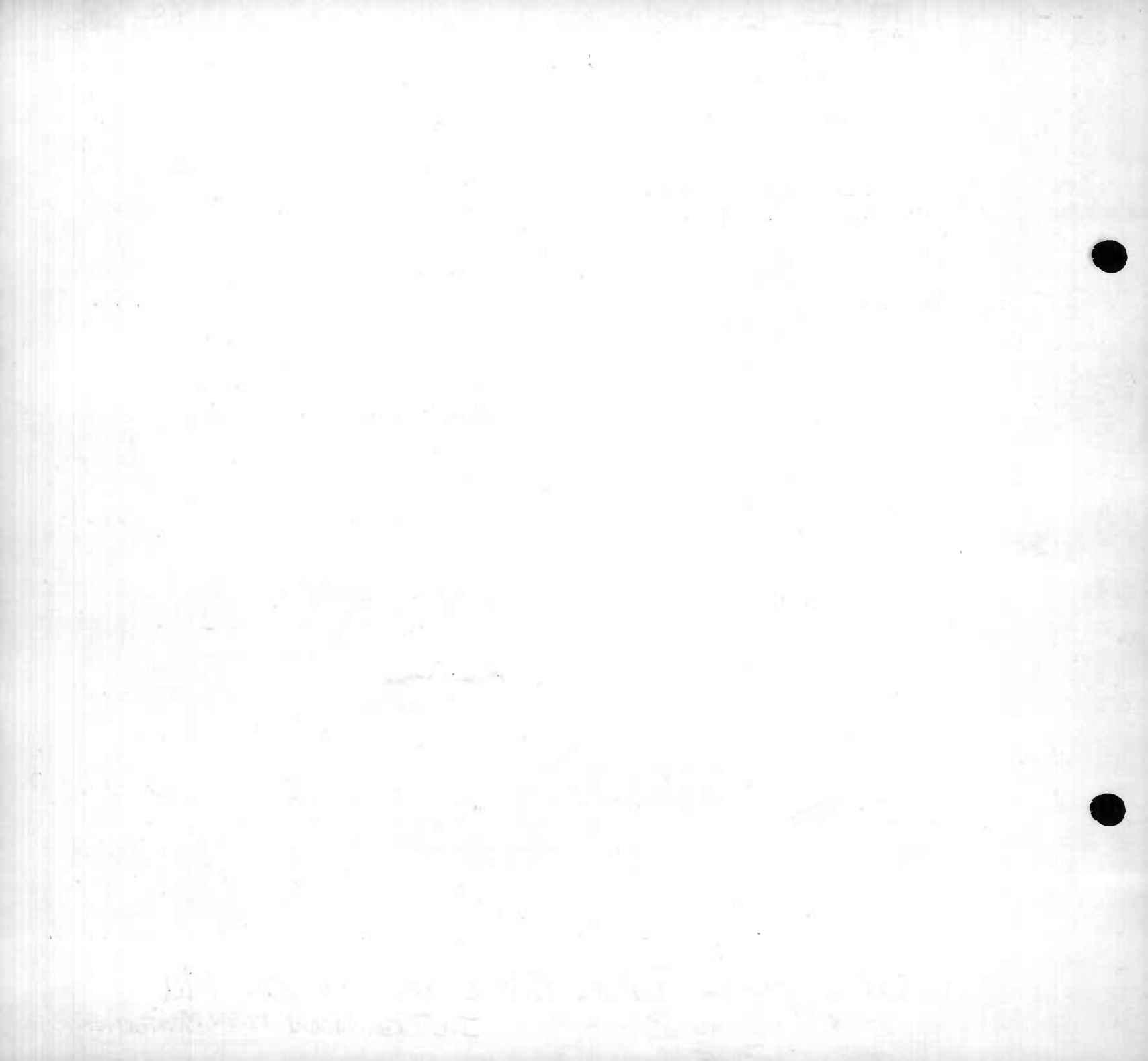
البريد الكويتي

52-04-43
CEK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9420	
1. NAME OF DECEASED (Type or Print) CORNISH, WINFIELD		2. DATE AND HOUR OF DEATH 9-4-68 850 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS		C. CITY OR TOWN BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
ADDRESS OR LOCATION 4940 EASTERN AVENUE		E. STREET AND NUMBER 704 SHARP STREET #21230			
BALTIMORE, MARYLAND #21224					
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS RECORDS: 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 1) prob. CVA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2) ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) anemia, and 3) to 1) renal disease 2) anemia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few hrs many years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 6-39 19 68 to 9-4 19 68 , that (I) <u>(we)</u> last saw the deceased alive on 9-4 19 68 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE LEE J. CORRAVE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/4/68	
23C. PHYSICIAN'S NAME (Type) LEE J. CORRAVE		23D. ADDRESS BCH: 4940 Eastern Ave., BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-12-68		24C. NAME OF CEMETERY OR CREMATORY BALTO NAT'L COM	
24D. LOCATION BALTO. Md					
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR I. L. Brown & Son 123 W. MONTGOMERY ST	



FUNERAL DIRECTOR: IMPORTANT

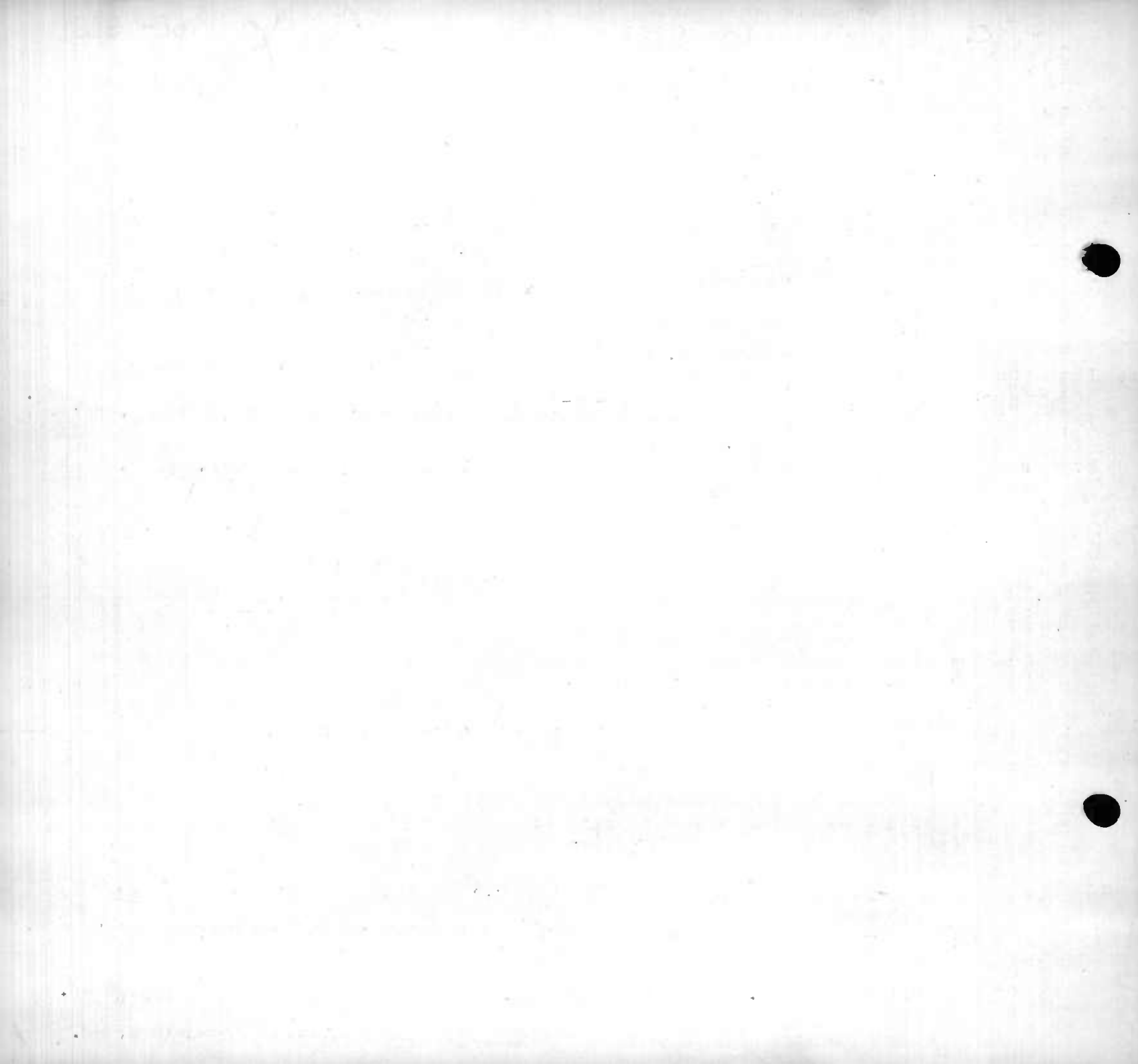
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9421 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9421

BIRTH NO.		1. NAME OF DECEASED (Type or Print) THOMAS H. KING		2. DATE AND HOUR OF DEATH 12:30^{2m} September 11, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Calvert Nursing Home B. COUNTY 54-00	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV OF MARYLAND HOSPITAL REDWOOD & GREEN STS. BALTIMORE MD.				C. CITY OR TOWN Prince Frederick, Md. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER UNKNOWN					
5. SEX MALE	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1878	9. AGE (In years lost birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN Farming		11. BIRTHPLACE (State or foreign country) UNKNOWN Maryland	
13. FATHER'S NAME UNKNOWN Thomas H. King			12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown No			16. SOCIAL SECURITY NO. 215-54-5125		
17. INFORMANT Calvert Nursing Home Prince Frederick, Md.			ADDRESS		
18. 1959 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY & Cardiac Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DUE TO AGING PROCESS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Surgery (amputation of @ hand) 12 hours (C) on 9-11-68					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 199.1 II					
19A. DATE OF OPERATION Sept 11, 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Hands		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 2 1968 to Sept 11 1968, that (I) (we) lost saw the deceased alive on Sept 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Silber, M.D. DEGREE				23B. DATE SIGNED 9-11-68	
23C. PHYSICIAN'S NAME (Type) Stanley Silber, M.D. DEGREE				23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 14/68		24C. NAME of CEMETERY or CREMATORY All Saints Chr. Cemetery	
24D. LOCATION Sunderland Calvert Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Pritchard Funeral Home Owings, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9422

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES SANDERS

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 114 W. Henrietta Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 9, 1968

7:08 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

June 23, 1922

10. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

114 W. Henrietta Street

11. BIRTHPLACE (State or foreign country)

Smithfield, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ronnie H. Sanders

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Old jobs

15. MOTHER'S MAIDEN NAME

Oru Sanders

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

17. SOCIAL
SECURITY NO.

238-44-9911

18. INFORMANT

Mr. Ronnie Sanders Jr.

ADDRESS 4602 D ST S.E.

Oct 6, Washington D.C 20019

19.

428X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Focal myocardial fibrosis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 10, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

24B. DATE

9/13/68

24C. NAME of CEMETERY or CREMATORY

Sanders Funeral Home Smithfield

24D. LOCATION (City, town, or county) (State)

N.C.

25A. DATE REC'D BY HEALTH DEPT.

SEP 17 1968

25B. NAME OF REGISTRAR

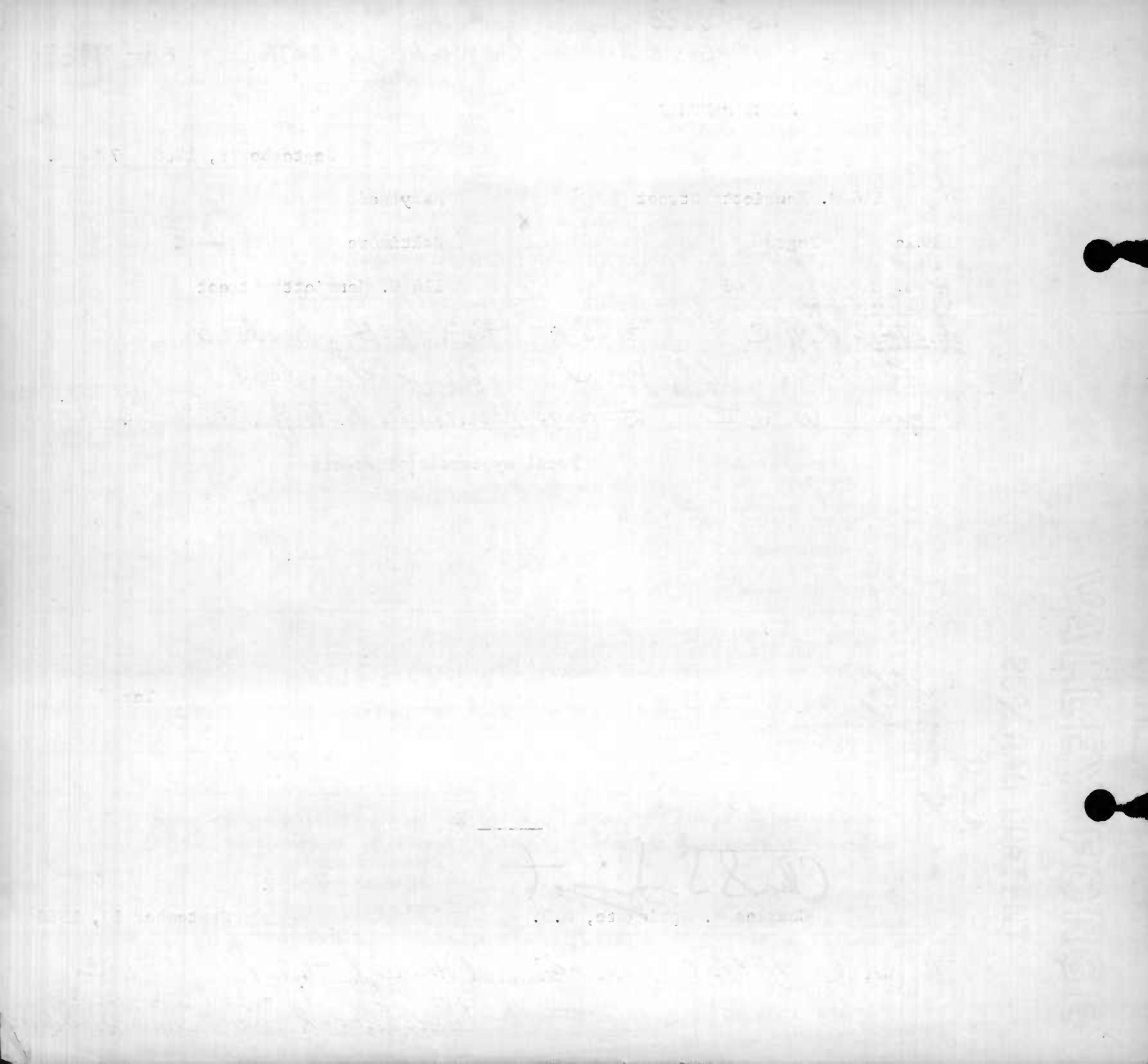
Robert E. Fairbairn

25C. FUNERAL DIRECTOR

Theresa E. Bell

ADDRESS

712-14 E. North Ave
Baltimore, Md 21202



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9423

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ERNEST DISIRO		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 16, 1968 5:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour September 16, 1968 5:45 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY V-35		C. CITY OR TOWN Philadelphia D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 3-29-1938	10. AGE (In years lost birthday) 38	E. STREET AND NUMBER 1631 McPherson St. 19150	
11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vincent DiSiro		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor	
15. MOTHER'S MAIDEN NAME Rose Marano		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean	
17. SOCIAL SECURITY NO. 191-22-7857		18. INFORMANT Charles L. DiSiro	
19. CAUSE OF DEATH E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of abdomen ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E987X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 8-15-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Wound of abdomen	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) tavern		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1319 E. Baltimore St. (Beachcomber Bar)	
22D. TIME OF INJURY (APPROX.) 9-15-68 8:55 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot during altercation		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DATE SIGNED September 16, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Removal		24B. DATE 9-20-68	
24C. NAME OF CEMETERY or CREMATORY Holy Sepulchre		24D. LOCATION (City, town, or county) (State) Montgomery Co. Pa.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md.	

2

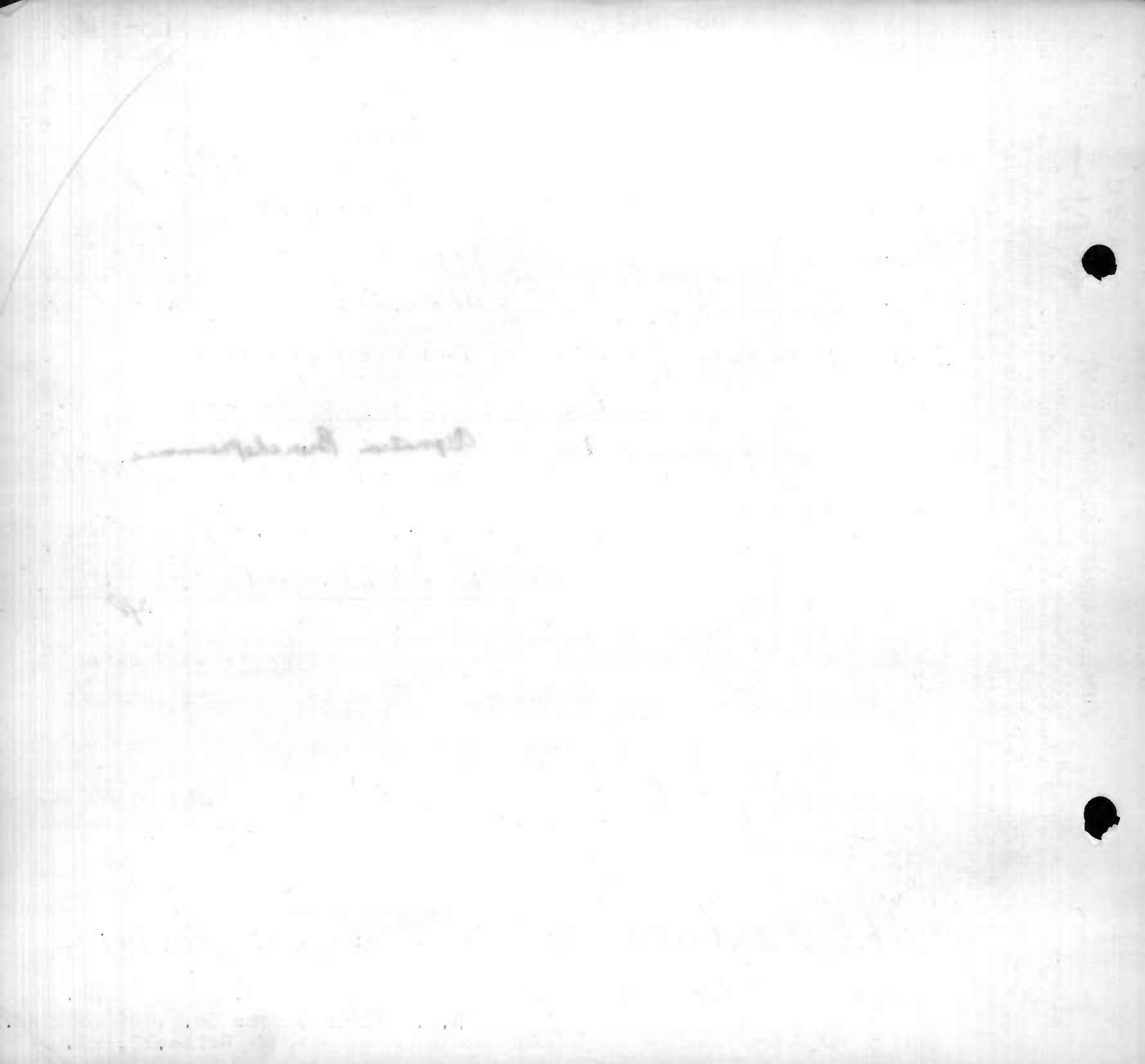
MAILED

POST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9424
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JANET L. ROSZEL		2. DATE AND HOUR OF DEATH September 16/1968 11 15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL Hospital			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1415 BOLTON ST		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1883	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (NONE) HOMEMAKER - HOME		10B. KIND OF BUSINESS OR INDUSTRY OWN		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN SOUTH GATE LEMMON			12. CITIZEN OF WHAT COUNTRY? (AMERICAN) U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 220-44-3056		17. INFORMANT R. JULIAN ROSZEL (same)
18. 491 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. respiratory insufficiency			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiorespiratory arrest (B) respiratory insufficiency (C) osmotic bacillus - septicemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/14/1968 1968 1965 78
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 5-02.0 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 14 19 68 to September 16 1968 , that (I) (we) last saw the deceased alive on September 15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique Ellenbogen MD				23B. DATE SIGNED 9/16/68	
23C. PHYSICIAN'S NAME (Type) Enrique Ellenbogen MD				23D. ADDRESS UNION MEMORIAL Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9425

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9425

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Robert Haynes		2. DATE AND HOUR OF DEATH 9/14/68 12 15 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1702 CRYSTAL AVE	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-13	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY City Employee		11. BIRTHPLACE (State or foreign country) Joppa, Maryland	
13. FATHER'S NAME DAVID HAYNES		14. MOTHER'S MAIDEN NAME EVA HARRIS		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 18-05-4419		17. INFORMANT Mrs Louise C. Gibson ADDRESS 721 Broadway Baltimore, Md	
18. 486 X 1-57100 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 493X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Alcoholic hepatitis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Alcoholic hepatitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/11 19 68 to 9/14 19 68 , that (I) (we) last saw the deceased alive on 9/14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David H. Katz M.D. DEGREE				23B. DATE SIGNED 9/14/68	
23C. PHYSICIAN'S NAME (Type) DAVID H. KATZ DEGREE				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/68		24C. NAME OF CEMETERY OR CREMATORY Lorley Methodist Cemetery	
24D. LOCATION (City, town, or county) (State) Lorley Baltimore County Md		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Haynes	
25C. FUNERAL DIRECTOR Elmer E. Bellink ADDRESS 712-14 East North Ave Baltimore, Md					

Received of the City of New York
the sum of \$10.00

for the purchase of
the sum of \$10.00

Received of the City of New York
the sum of \$10.00

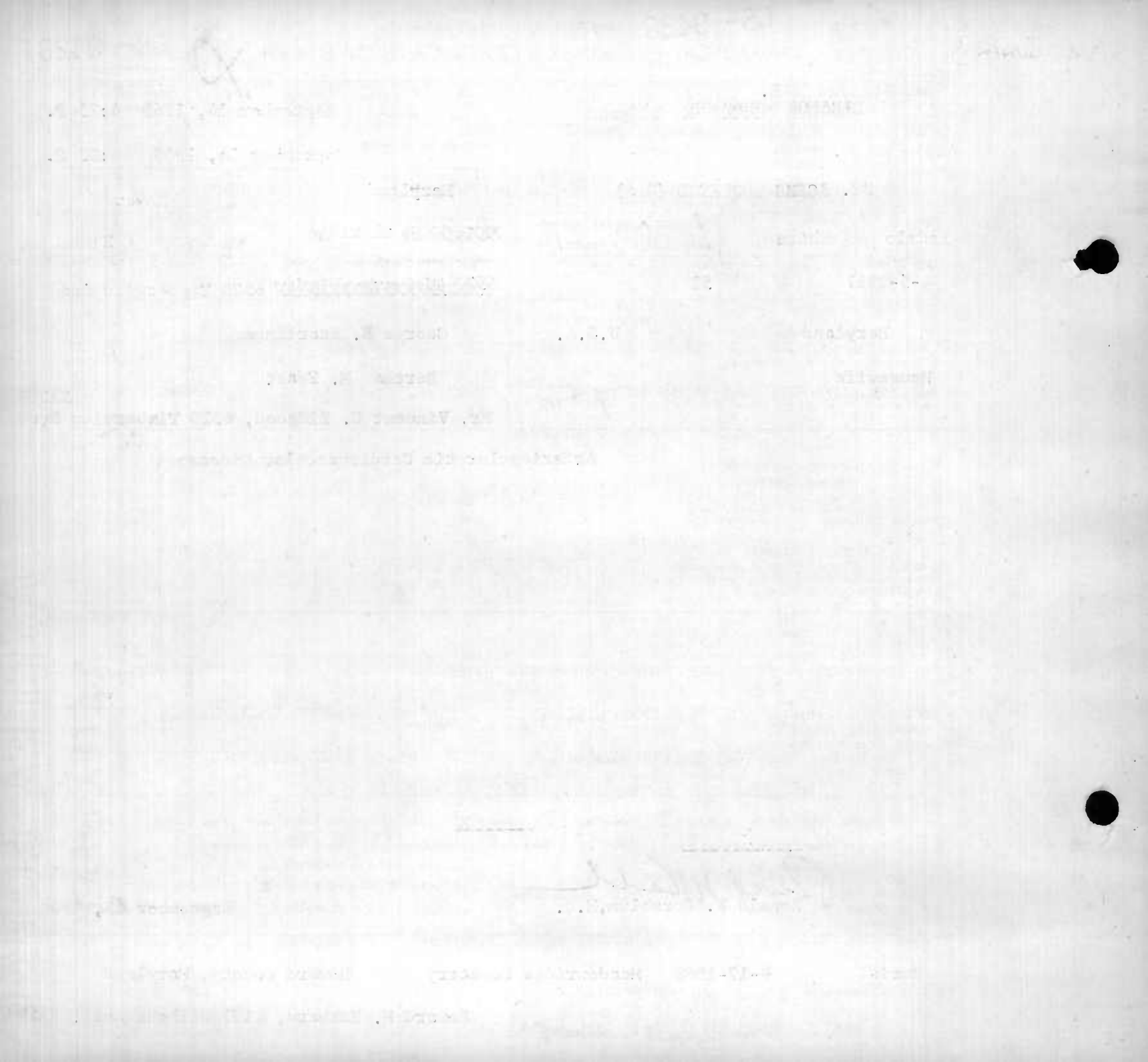
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9426

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELEANOR BIDGOOD Bidgood		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 14, 1968 4:25 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 14, 1968 4:25 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard 63-00		C. CITY OR TOWN Elkridge D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX Female	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-5-1917	10. AGE (In years lost birthday) 51	E. STREET AND NUMBER 6520 Timberview Road	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. Vincent C. Bidgood, 6520 Timberview Road		ADDRESS 21227	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 7-22-1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED September 15, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-17-1968	24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	24D. LOCATION (City, town, or county) (State) Howard County, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9427

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) **CARLTON ALLEN BARNETT**2. DATE
OF
DEATHKnown ☐ Month Day Year
Estimated ☐ **September 15, 1968**Hour
1:40 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
CHURCH HOME AND HOSPITAL (DOA) 9-273. DATE
PRONOUNCED DEADMonth Day Year
September 15, 1968Hour
1:40 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Maryland**

B. COUNTY

6. SEX

Male

7. RACE

Negro8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

5-24-44

10. AGE (In years)

24

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

4644 Pall Mall Road

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Willie Peterson

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Merchant Seaman

15. MOTHER'S MAIDEN NAME

Mary Barnett

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

216-42-9428

18. INFORMANT

Mrs. Margie Barnett-1759-Darley-Ave.-21218-19. **E-966X**

CAUSE OF DEATH

Stab wound of chest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

5-9-68

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

In front of 1321 E. Baltimore Street

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

Sept. 15, 1968 1:25 A.M.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stab wound of chest

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)**Ronald N. Kornblum, M.D.**CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 15, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-19-68

24C. NAME OF CEMETERY or CREMATORY

**Arbutus Memorial Park
Mt. Calvary Cemetery**

24D. LOCATION (City, town, or county) (State)

A.A. Co., Maryland

25A. DATE REC'D BY HEALTH DEPT

SEP 17 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

ADDRESS

1735 Harford Ave. 21213

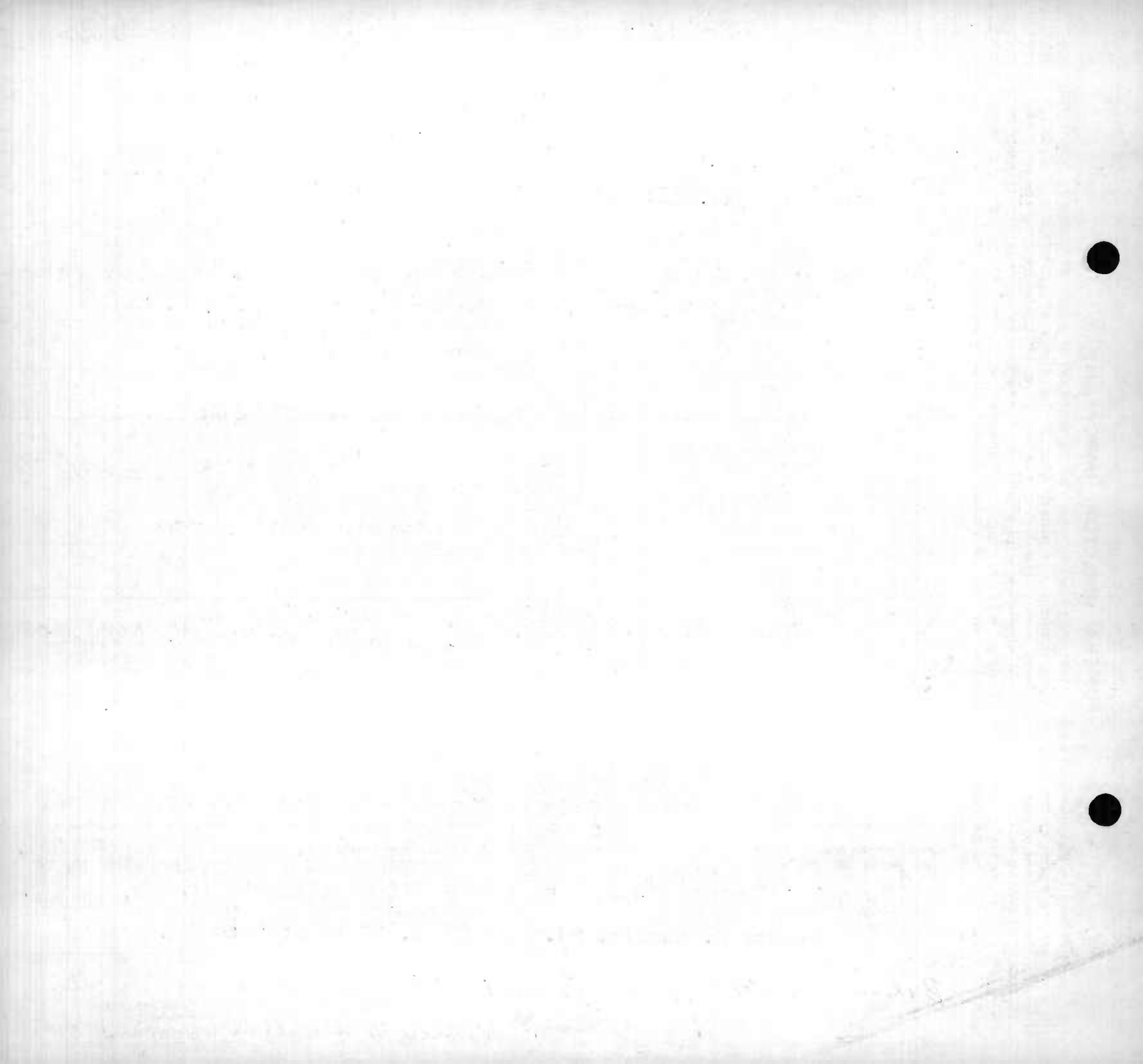
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9428 CERTIFICATE OF DEATH

REG. NO. 68- 9428

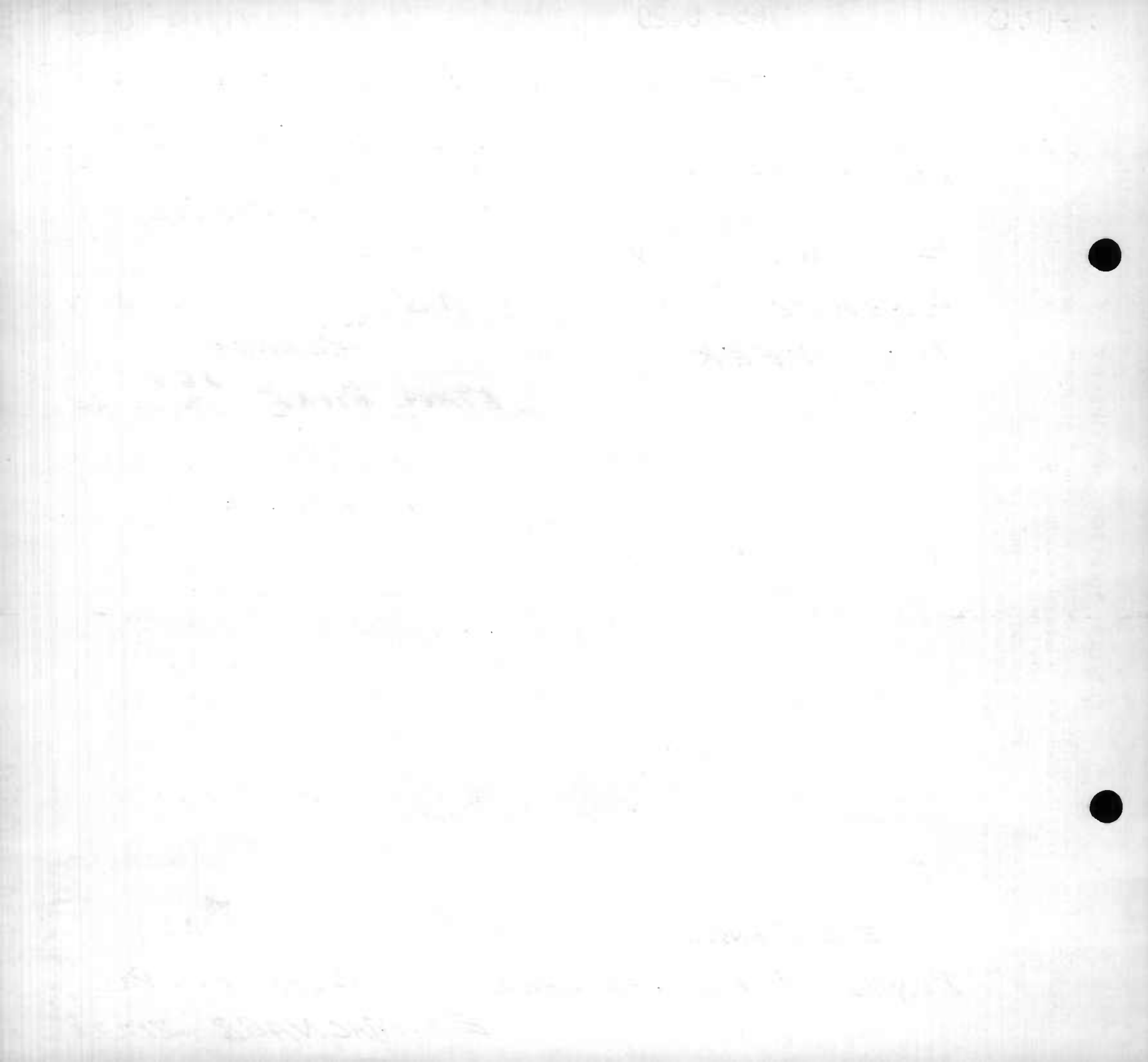
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN BANKS		9-13-68 10:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				MARYLAND	
307 E. 24th St. BALTO., Md. 21218				C. CITY OR TOWN BALTIMORE	
				E. STREET AND NUMBER 307 E. 24th Street	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		COLORED		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Laborer		Hod Carrier		1-7-99 69	
11. BIRTHPLACE (State or foreign country)				9. AGE (In years last birthday)	
Gloster Co., Virginia				69	
12. CITIZEN OF WHAT COUNTRY?				If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
U.S.A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Alex Banks				Mary Lewis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		213-12-8564		Mrs. Annie Banks 307 E. 24th St. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
420.0 II				6 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				ACIDOSIS + dehydration due to carcinoma of the esophagus five mos.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9-11 1968 to 9-13 1968, that (I) (we) lost saw the deceased alive on 9-13 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Feodor C. Caguin, Md.					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Feodor C. Caguin, Md.				336 E. 25 th Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		9-18-68		CARVER MEMORIAL PARK- LAUREL Md.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 17 1968		Robert E. Jankovic		MARSHALL W. JONES JR 1735 ADDRESS HARFORD AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9429	
68-9429 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDITH N. WEBB		2. DATE AND HOUR OF DEATH SEPT. 13, 1968 4:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTO.		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSP.			C. CITY OR TOWN CATONSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 6 SOUTH BEECHWOOD AVE		
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/27/84	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WM. MEEK			14. MOTHER'S MAIDEN NAME SCAGGS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ETHEL BOONE ADDRESS 8419 PHILA. RD.
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thromboses ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 20 years			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardio-Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Heart Disease (C) _____		
19. DATE OF OPERATION 420.1 II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis Chronic		20A. AUTOPSY? (Yes or No) 2 days
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Nov 10, 1949 to 9/13/68 , that (I) (we) last saw the deceased alive on 9/13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elmer W. Johnson			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) E.W. JOHNSON
23D. ADDRESS 3432 Judsonville Ave			23E. CITY, TOWN, OR COUNTY BALTIMORE MD 21229		
24A. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL			24B. DATE 9/16/68		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN
24D. LOCATION BALTO. CO. MD.			24E. STATE MD.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR E.S. MACNABR		25C. FUNERAL DIRECTOR 21228
25D. ADDRESS 21228					



FUNERAL DIRECTOR: IMPORTANT

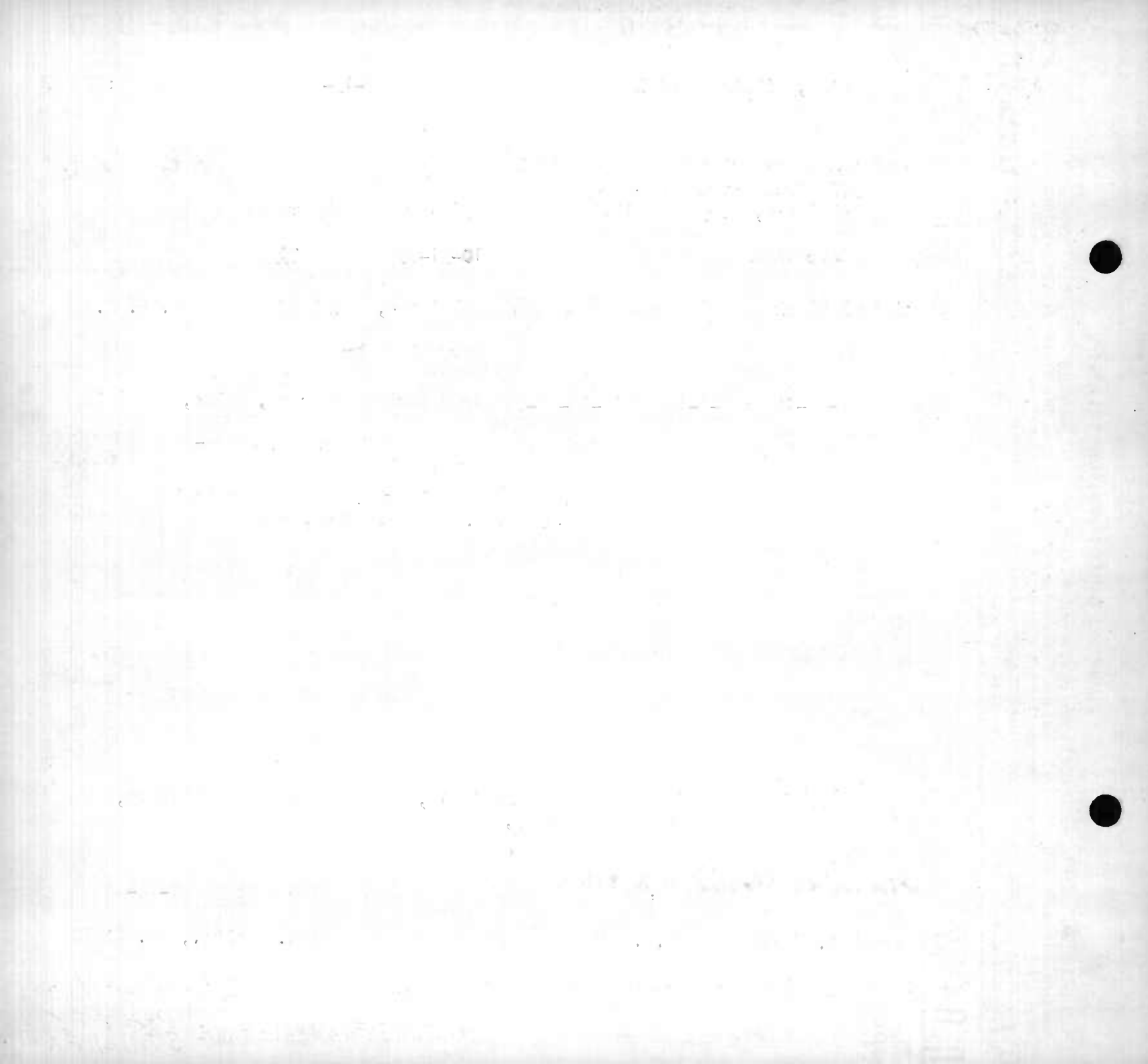
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause at death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9430 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9430

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PLACK, William Daniel		2. DATE AND HOUR OF DEATH 9-13-68 8:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES 28-04 NO
5. SEX Male			6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-95
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistical Clerk			10B. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY		9. AGE (In years last birthday) 72
13. FATHER'S NAME John Plack			14. MOTHER'S MAIDEN NAME Mary Glathaar		12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7-20-17 to 8-6-19			16. SOCIAL SECURITY NO. 219-42-62-06		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd, Balto, Md 21218
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Emphysema of lungs With acute tracheo-bronchitis			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Peptic esophagitis with gastrointestinal hemorrhage. Clitis, acute, marked		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Month
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		years
322.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C)		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that 11 (this hospital) attended the deceased from April 12, 19 68 to September 13, 19 68 , that 11 (we) last saw the deceased alive on September 13, 19 68 and that in 11 (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) did not view the body after death.					
23A. SIGNATURE Fayek G. Yassa, M.D., FACS				23B. DATE SIGNED 9-14-68	
23C. PHYSICIAN'S NAME (Type) Fayek G. Yassa		23D. ADDRESS M.D. FACS 3900 Loch Raven Blvd. Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-18-68		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL	
24D. LOCATION BALTIMORE, MARYLAND.		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR WALTERS FUNERAL HOME			
25D. ADDRESS PRATT & STRICKER STS.					

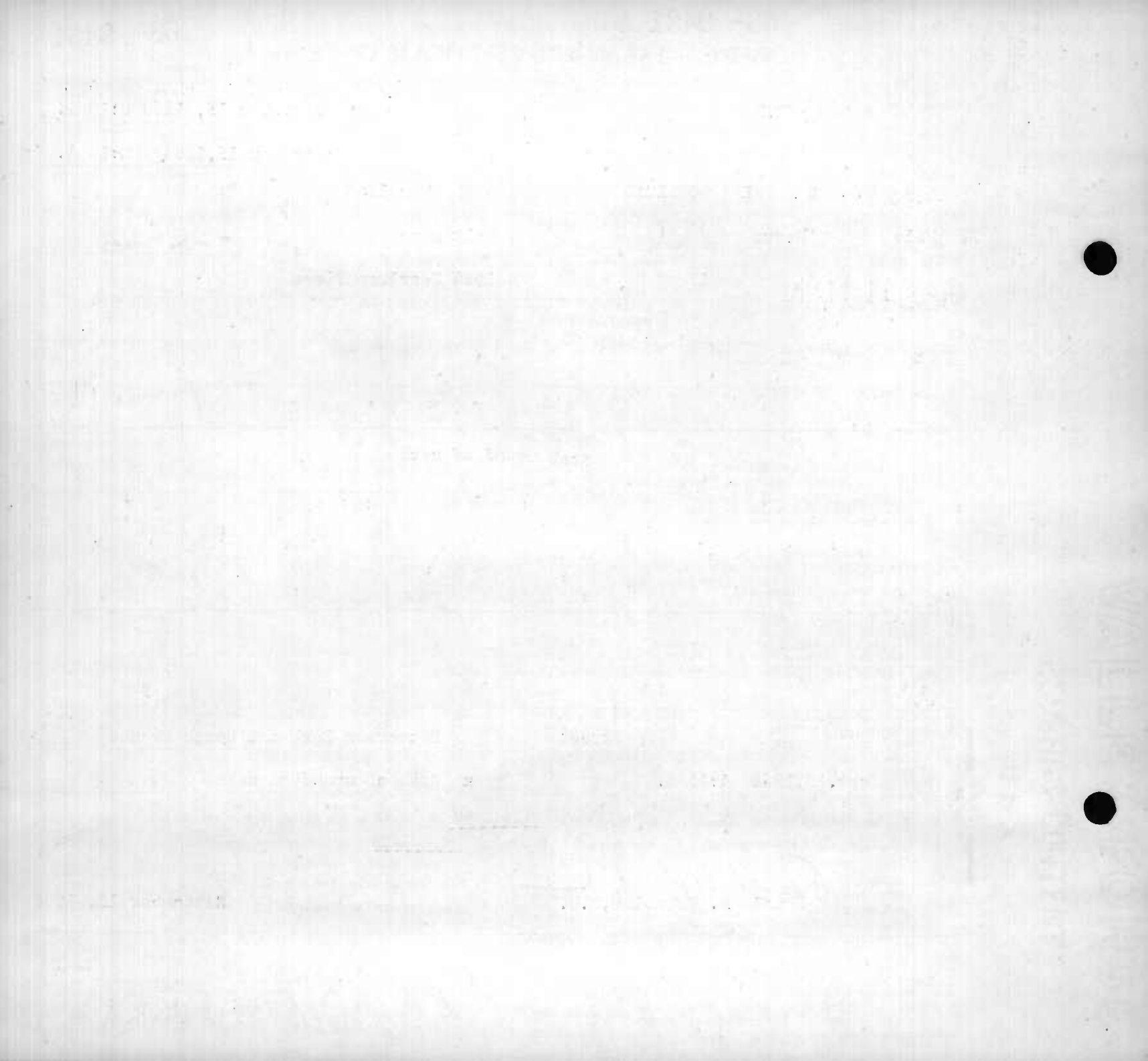


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) AARON WHITE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 15, 1968 8:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 15, 1968 8:10 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug. 19, 1951		10. AGE (In years lost birthday) 17	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. E966X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Stab wound of neck (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Patterson Park and North Avenue		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Sept. 15, 1968 1:15 A.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed wound of neck	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 15, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/68	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Phila. Pa.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Sam [unclear]		ADDRESS 1712 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9432
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Mr. John P. Edwards		9-16-68 11:45 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
BARTON BLDG. 519 Church Home & Hospital			A. STATE Maryland B. COUNTY Baltimore	
5. IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN D. INSIDE CITY LIMITS?	
172203			Balto. XXXX NO <input checked="" type="checkbox"/>	
1 20 00			E. STREET AND NUMBER	
MED 8-22-68			1222 Ingleside Avenue 7	
6. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male	White		1-20-1900	68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Gen. Traffic Manager			Virginia	USA American
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME	
Virgil Edwards			Cornelia Philpott	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO			231-09-9809	1222 Ingleside Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF	
ANTECEDENT CAUSES			Penpheral Circulatory failure	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Bladder Carcinoma with extensive metastasis	
187.0 II			(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				<input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 8-22-1968 to 9-16-1968, that (I) (we) last saw the deceased alive on Sept 16 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Jose F. Mier Jr. M.D.				9-16-68
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Jose F. Mier Jr. M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	9-19-68	Pleasant Grove Cemetery	Martinsville, Va.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
SEP 17 1968	Ed. E. Fink	Ellsworth Armacost-4600 Liberty Hgts.		

1235 Superior Avenue

CO

W

W

W

Vandria

His Father

Gen. John

Constance Philip

And Edwards

1235 Superior Avenue

1235 Superior Avenue

1235 Superior Avenue

1235 Superior Avenue

1235 Superior Avenue

1235 Superior Avenue

1235 Superior Avenue

1235 Superior Avenue

1235 Superior Avenue

1235 Superior Avenue

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9433
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE ZBORAI, SR.		2. DATE AND HOUR OF DEATH Sept 15, 1968 4:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 4877D. GENL. HOSP			C. CITY OR TOWN Essex 21221		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER Box 750 "B" Bauernschmidt Manor		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1922	9. AGE (In years last birthday) 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Tire Co.		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME George Zborai			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1940-1960		
16. SOCIAL SECURITY NO. 217 26 8310			17. INFORMANT. ADDRESS Helen J. Zborai Same		
18. 410.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. myocardial infarct ASCVD - years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 min	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 15 1968 to Sept 15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A S G LUSHAROW				23B. DATE SIGNED 9-15-68	
23C. PHYSICIAN'S NAME (Type) A S G LUSHAROW				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968			
25B. NAME OF REGISTRAR John E. Jankins		25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.			

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68- 9434	
BIRTH NO. 68- 9434				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LEE LEWIS BYRDSONG			2. DATE AND HOUR OF DEATH 9/14/68 6 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-04 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 902 Shuter Street		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 15 97	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (R)			11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219056717	17. INFORMANT ADDRESS LELA Byrdson 902 N. Shuter St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchogenic ca (B) Chronic emphysema (C) Fe deficiency anemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 mos 20 yrs 5 yrs.
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 162.1 II					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12N 9/14/19 68 to 6 AM 9/14/19 68 , that (I) we lost saw the deceased alive on 9/14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.					
23A. SIGNATURE Edward Block M.D.			23B. DATE SIGNED 9/14/68		23C. PHYSICIAN'S NAME (Type) Edward Block M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 9/19/68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968			25B. NAME OF REGISTRAR John E. Schuyler		25C. FUNERAL DIRECTOR ADDRESS Joseph J. Block Jr 1504 N Central Ave

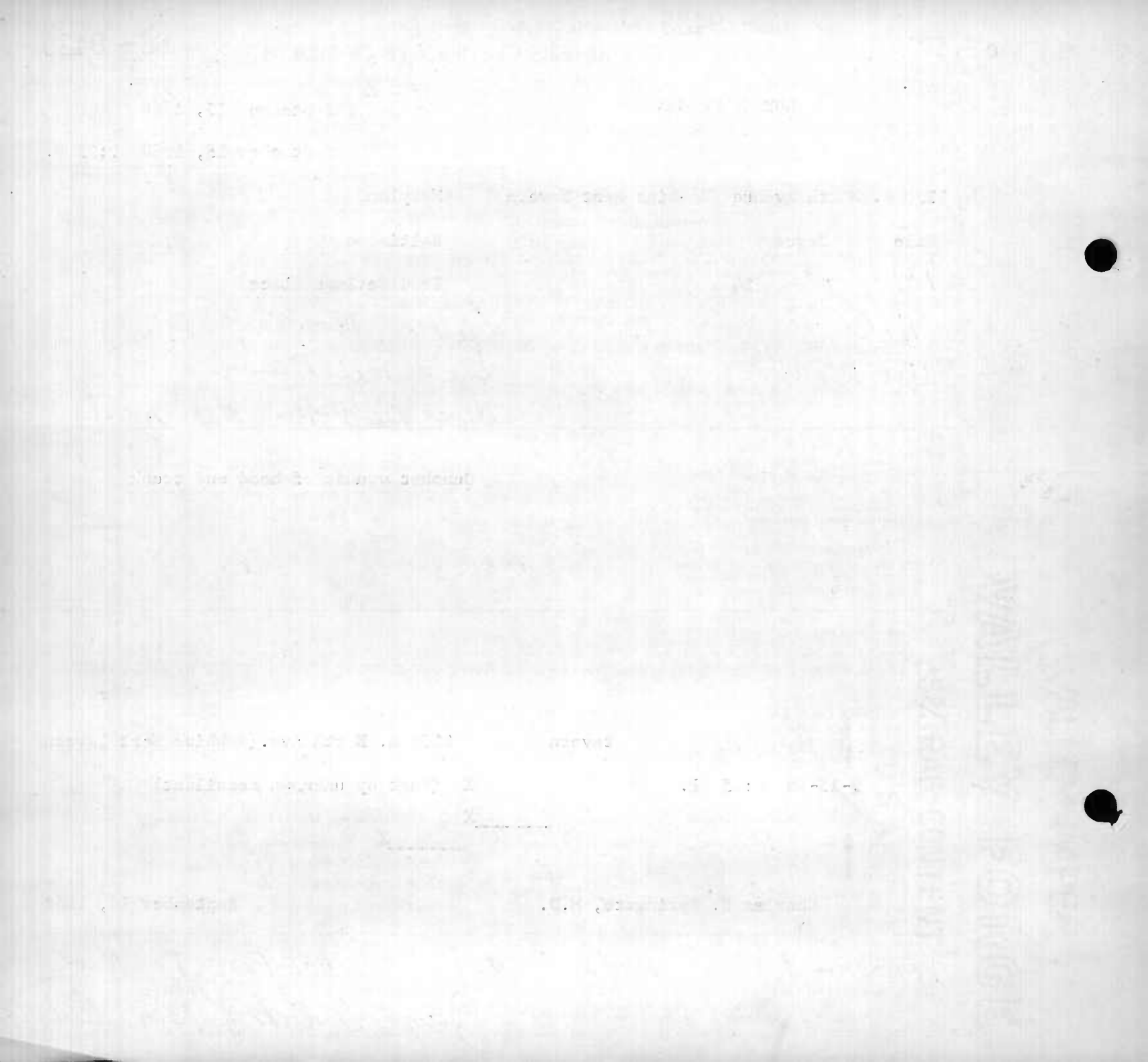
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9435

REG. NO.

BIRTH NO.

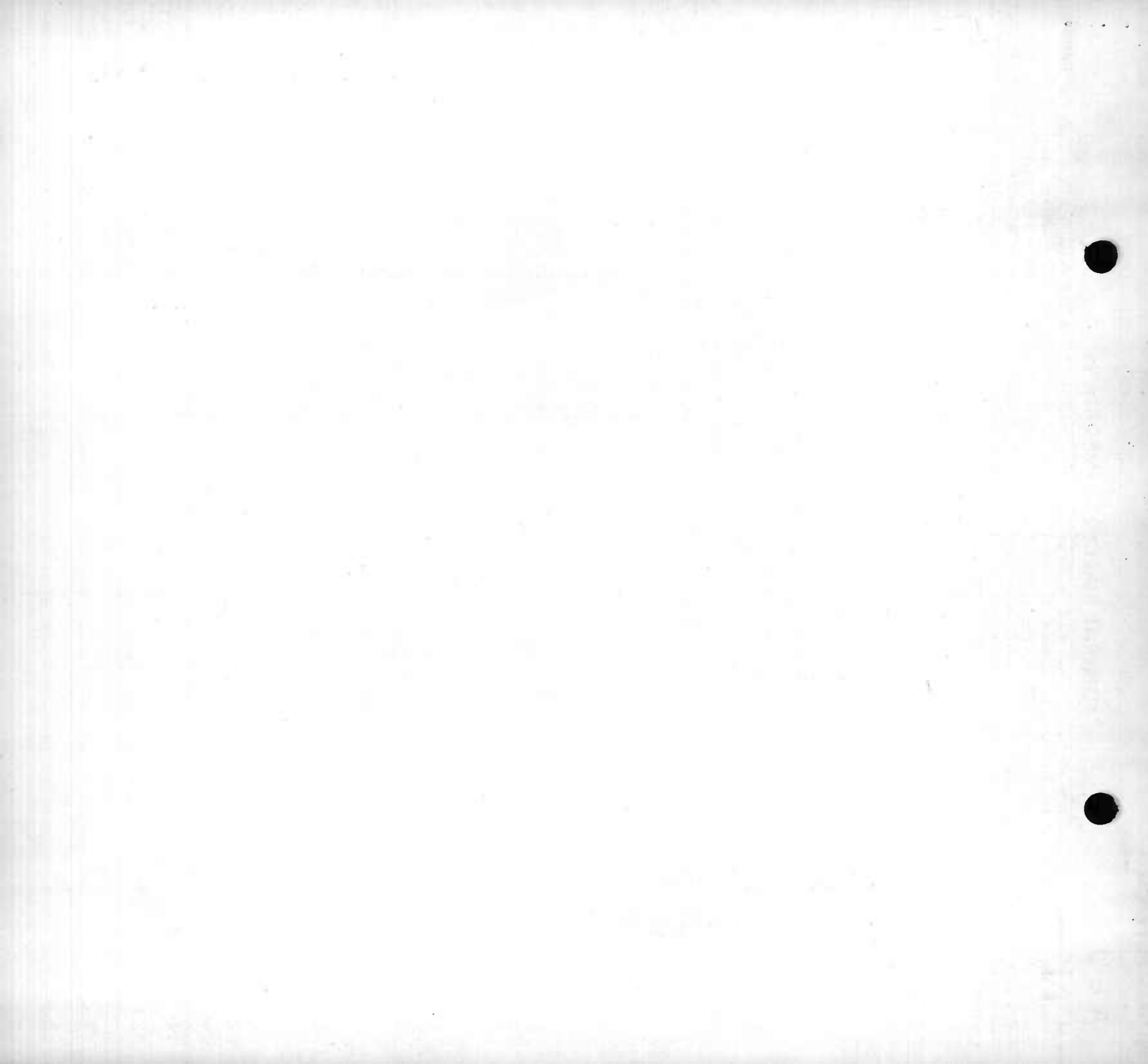
1. NAME OF DECEASED (Type or Print) LUTHER MORGAN				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 15, 1968 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2250 E. North Avenue (Robbins Nest Tavern)				3. DATE PRONOUNCED DEAD Month Day Year Hour Septmeber 15, 1968 7:25 P. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY							
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/1/43		10. AGE (In years lost birthday) 24		11. BIRTHPLACE (State or foreign country) N.C.		D. INSIDE CITY LIMITS? 5 YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repairer				14B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER 1900 Perlman Place	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		13. FATHER'S NAME Luther Morgan	
15. MOTHER'S MAIDEN NAME Susie Mae Dunn				18. INFORMANT Thomas Lee Morgan		ADDRESS Wake Forest. N.C.	
19. E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of head and trunk				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gunshot wounds of head and trunk			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E981X II				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) tavern			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2250 E. North Ave. (Robbins Nest Tavern)				22F. HOW DID INJURY OCCUR? (Shot by unknown assailant)			
22D. TIME OF INJURY (APPROX.) 9-15-68 6:45 P. m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 16, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 9/18/68		24C. NAME OF CEMETERY or CREMATORY WAKE FOREST		24D. LOCATION (City, town, or county) (State) WAKE FOREST N.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Joseph E. Lock		ADDRESS 1304 N. [unclear]	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9436
BIRTH NO. 1. NAME OF DECEASED (Type or Print) LEROY SYKES		2. DATE AND HOUR OF DEATH 9-16-68 12:15 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 302 KENDALL ROAD C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 302 Kendall Road			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/14/1900	9. AGE (In years last birthday) 68 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME George S. Sykes			
14. MOTHER'S MAIDEN NAME Ashton		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --			
16. SOCIAL SECURITY NO. 212-05-4414		17. INFORMANT ADDRESS Harry S. Sykes 3904 Falls Road 21211			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE Uremia DUE TO, OR AS A CONSEQUENCE OF: (B) Renal shutdown DUE TO, OR AS A CONSEQUENCE OF: (C) G.I. Bleeding - Intestinal Congestion </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 3-78X II					
19A. DATE OF OPERATION 14/13/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fair		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/4/68 19 to 9/16/68 19, that (I) (we) last saw the deceased alive on 9/15/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. R. Chloca, M.D. Intern				23B. DATE SIGNED 9/16/68	
23C. PHYSICIAN'S NAME (Type) I. R. CHLOCA, INTERN				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/68		24C. NAME OF CEMETERY or CREMATORY St. Marys Cemetery (Hampden)	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968			
25B. NAME OF REGISTRAR Robert E. Fabela		25C. FUNERAL DIRECTOR ADDRESS Frank H. Seitz 814 N 36 St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9437 CERTIFICATE OF DEATH

REG. NO. 68- 9437

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BENJAMIN (BENNY) J. SNIADACH		2. DATE AND HOUR OF DEATH SEPT. 13, 1968 1250 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTO.		
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 109 S. POTOMAC ST.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/1910	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSEMAN		10B. KIND OF BUSINESS OR INDUSTRY MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JANACEY			14. MOTHER'S MAIDEN NAME ANNA KUCZ		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW-2		16. SOCIAL SECURITY NO. 216-10-4733		17. INFORMANT Josephine SNIADACH	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ac. coronary thrombosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic heart D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: 6 years		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 62 19 68 to 9-12 19 68 , that (I) (we) last saw the deceased alive on 8-10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 9-13-68	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS 3209 Old North St. Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/14/68		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEM.	
24D. LOCATION BALTO. MD.		24E. NAME OF REGISTRAR [Signature]		24F. FUNERAL DIRECTOR B. PABLOWSKI	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR B. PABLOWSKI	
25D. ADDRESS 2815 E. BALTO ST.					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HOWARD N. JOHNSON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

September 14, 1968

9:24 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

HOPKINS HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 14, 1968

9:24 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒ NO ☐

9. DATE OF BIRTH

3-3-05

10. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2205 Prentiss Place

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Neil Johnson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Pipe Fitter

14B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel

15. MOTHER'S MAIDEN NAME

Susie B. Hankford

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, note unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

212013437

18. INFORMANT

Josephine E. Johnson

ADDRESS

2205 Prentiss Place

19.

E 929X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Craniocerebral Injuries

(A) IMMEDIATE CAUSE

~~Spontaneous Intracerebral Hemorrhage~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Spontaneous Intracerebral Hemorrhage

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

SPONTANEOUS INTRACEREBRAL Hemorrhage

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2205 Prentiss Place

22D. TIME
OF INJURY
(APPROX.)

Sept. 14, 1968 9:00 P.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Found at bottom of cellar steps

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 15, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-18-68

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

Baltimore Md

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 17 1968

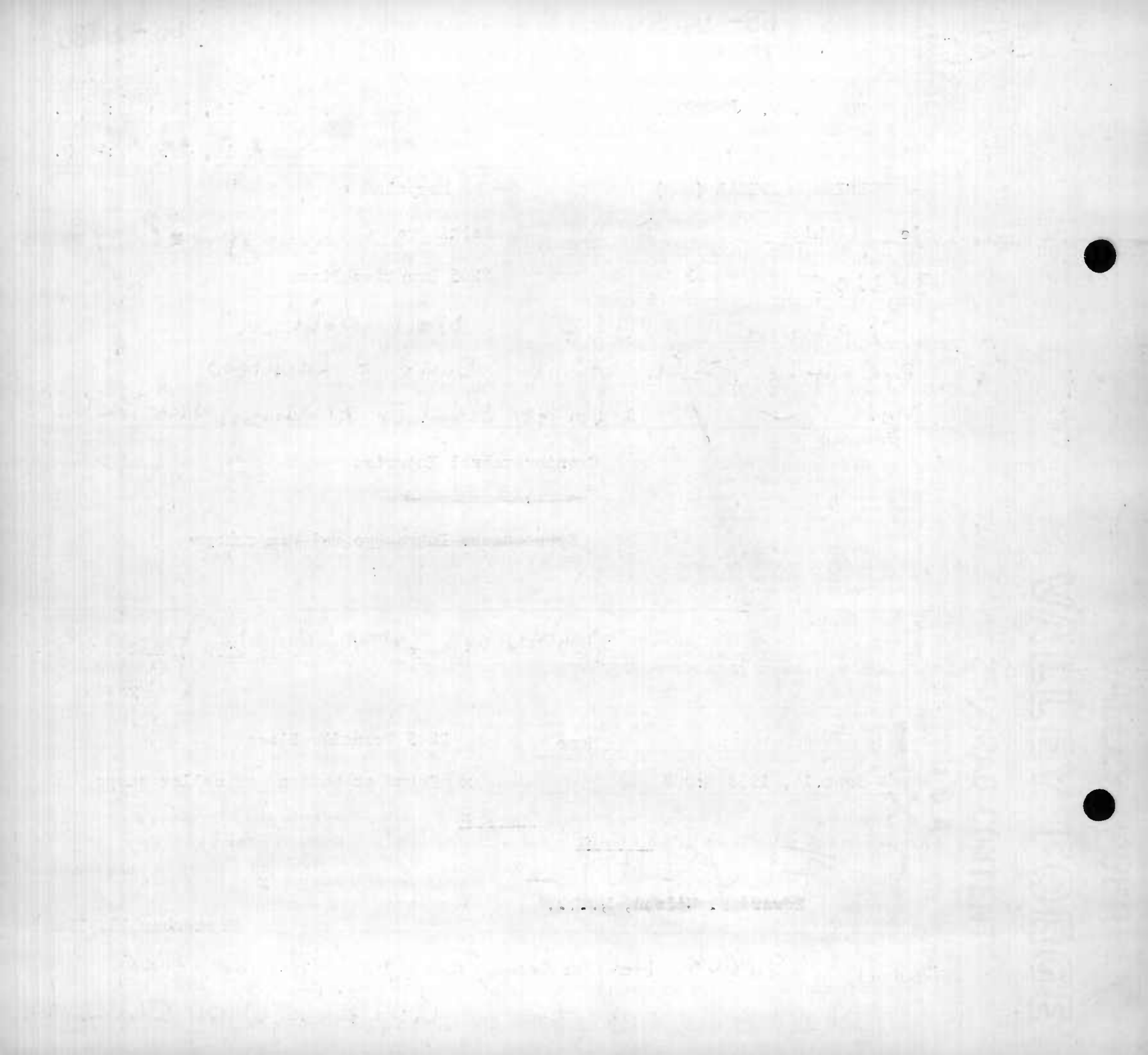
25B. NAME OF REGISTRAR

R. E. J. Farley

25C. FUNERAL DIRECTOR

Philip E. Crach 124 Chesapeake

ADDRESS



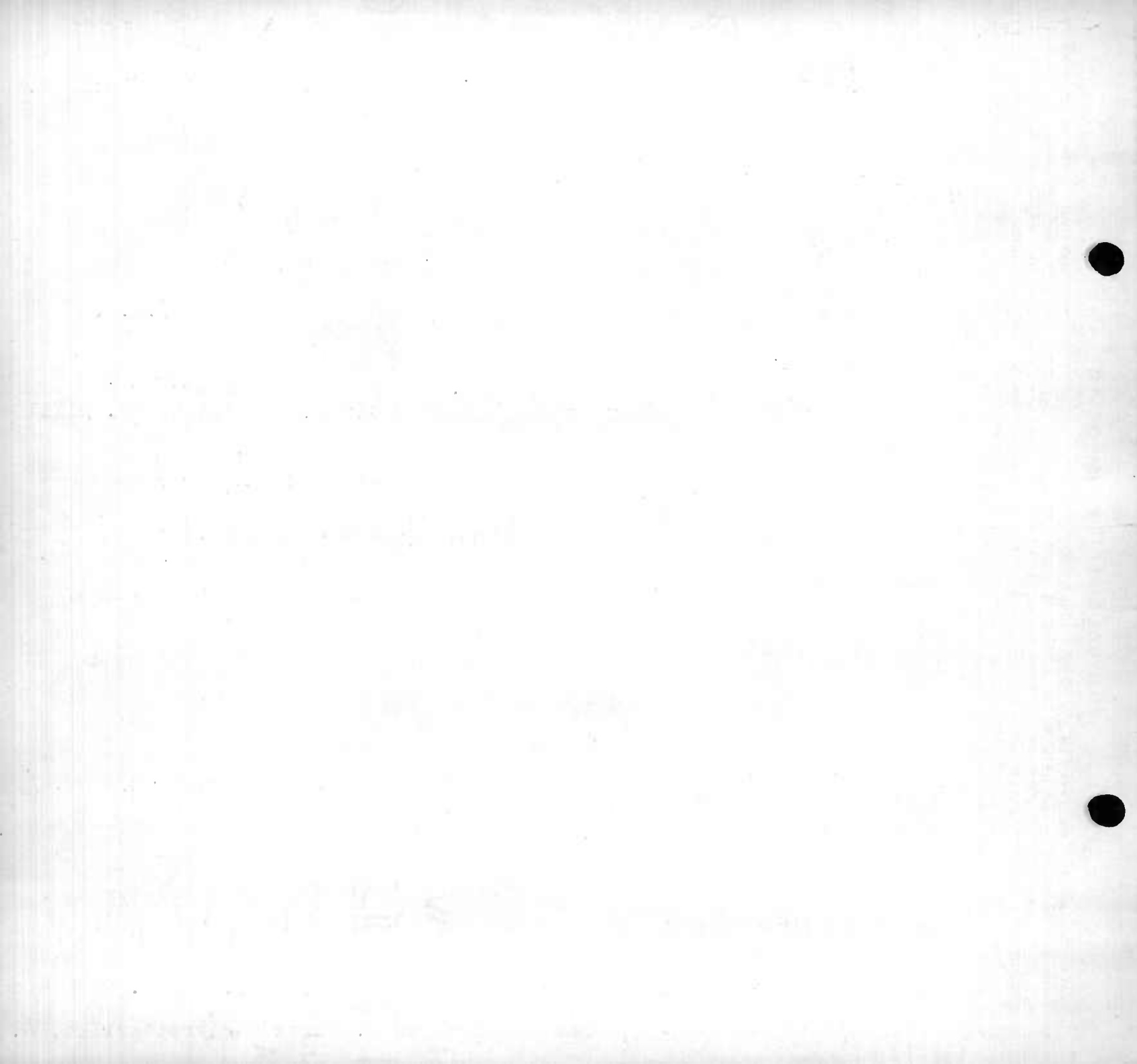
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9439 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT
REG. NO. 68- 9439

BIRTH NO.		1. NAME OF DECEASED (Type or Print) REBA JACKSON		2. DATE AND HOUR OF DEATH 9/14/1968 4:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital Of Maryland 730 Ashburton Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Monkton D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2822 Ashburton Road			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/1892	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Larkins		14. MOTHER'S MAIDEN NAME Mary Lewis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-7250		17. INFORMANT Mrs. Gladys Robinson	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac failure. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial infarct.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/25 19 68 to 9/14 19 68 , that (I) (we) last saw the deceased alive on 9/14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.S. Ming		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/14/1968	
23C. PHYSICIAN'S NAME (Type) CHEE SHWE MING		23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/17/68		24C. NAME OF CEMETERY or CREMATORY Pine Grove	
24D. LOCATION White Hall, Balto. Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Charles B. Kurtz	
				ADDRESS Jarrettsville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9440	
68- 9440				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) GOMPERTZ, BERNARD L.				2. DATE AND HOUR OF DEATH 9/15/1968 4:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSP.				A. STATE MD	
				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 110 S. Calender St.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/1890	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) HOLLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME unknown		
14. MOTHER'S MAIDEN NAME unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 26-10-0410A			17. INFORMANT ANNA MARIE GOMPERTZ		
18. CAUSE OF DEATH			ADDRESS BALTO. MD. 110 CALLENDER ST.		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Myocardial Infarction 30 min		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF: Coronary Heart Disease 2 yrs		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1/66 19 to 9/15/68 19, that (I) (we) last saw the deceased alive on 9/15/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. MuneSES, M.D.				23B. DATE SIGNED 9/16/68	
23C. PHYSICIAN'S NAME (Type) 888 W. LOMBARD ST. BALTIMORE, MD. 21201				23D. ADDRESS John J. Kowarsky Inc. 23rd St. 23rd fl.	
24A. BURIAL CREAMATION OR REMOVAL (Specify) BURIAL				24B. NAME OF CEMETERY OR CREMATORY CREST LAWN CEM.	
24C. LOCATION (City, town, or county) Howard Co.				24D. LOCATION (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Sanku		25C. FUNERAL DIRECTOR John J. Kowarsky Inc.	

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

FUNERAL DIRECTOR: IMPORTANT

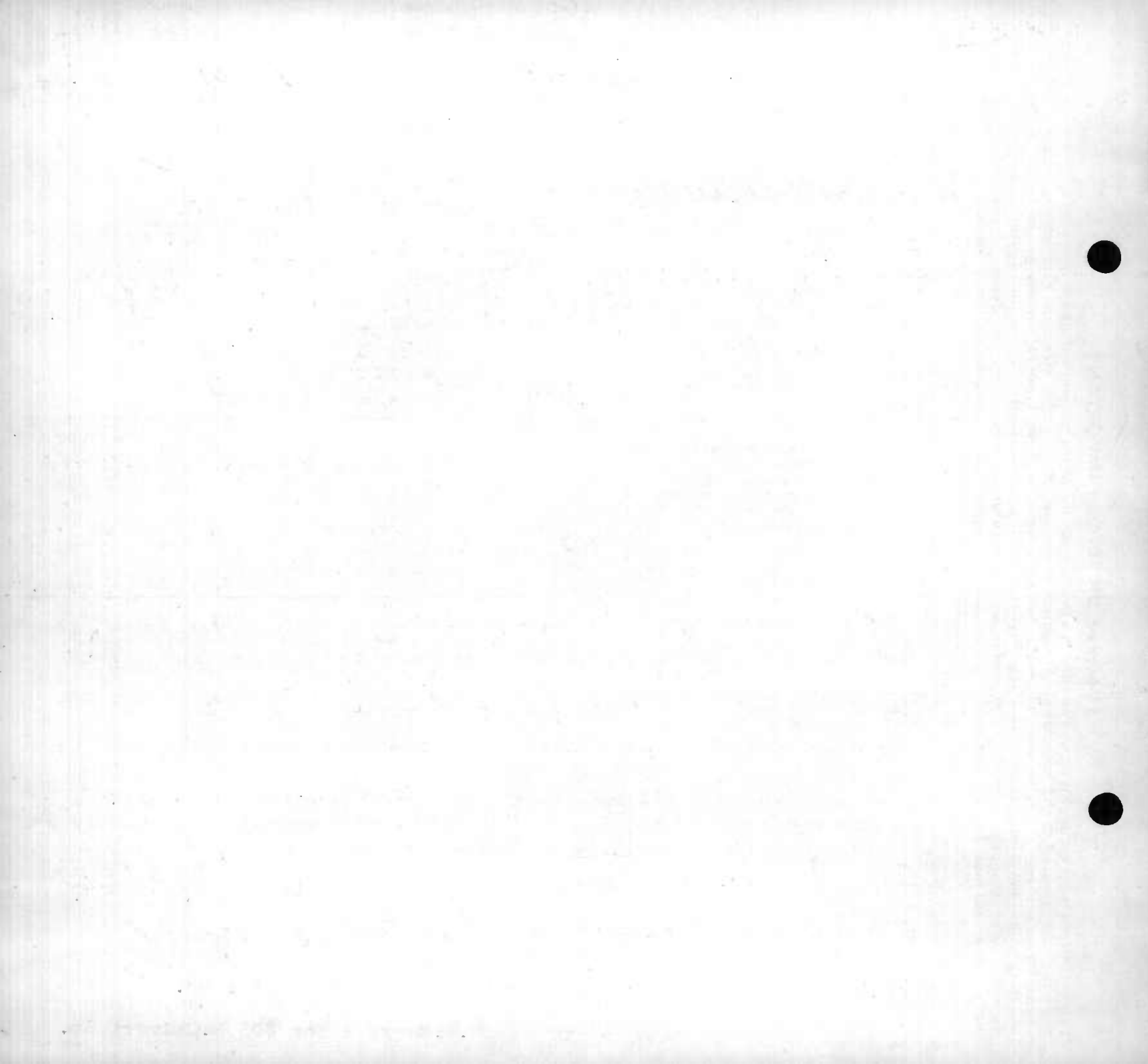
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9441

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. 68- 9441

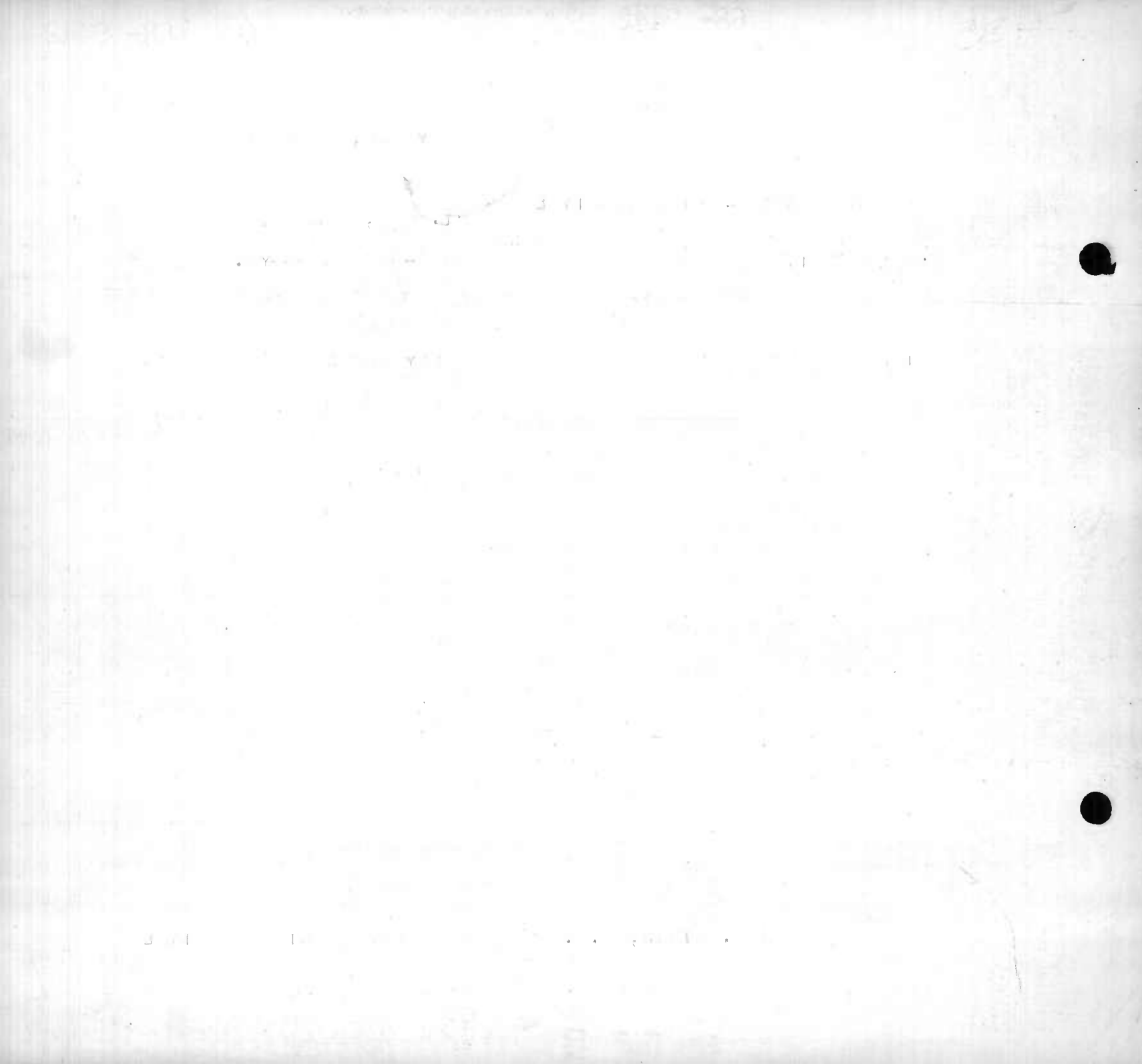
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Marie Mc Donnell</i>		2. DATE AND HOUR OF DEATH <i>Sept 10, 1968 6:00A M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>91 Montebello Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Wic.</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1017 N. Calvert St.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>10-22-24</i>	9. AGE (In years last birthday) <i>44</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>waitress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Unemployed</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>William Mc Donnell</i>			14. MOTHER'S MAIDEN NAME <i>Regina Mc Dermott</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>164-166-865</i>		17. INFORMANT <i>Hospital Chart</i>	
				ADDRESS	
18. <i>180X I</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cancer of Cervix</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Unknown Cause</i> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
171X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-5 1967</i> to <i>9-11 1968</i> , that (I) (we) last saw the deceased alive on <i>9-11 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Cesar J. Pellerano, M.D.</i> DEGREE				23B. DATE SIGNED <i>9-11-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellerano, M.D.</i> DEGREE				23D. ADDRESS <i>Montebello Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/13/68</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 17 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>H.W. Mears & Son</i>	
				ADDRESS <i>805 N. Calvert St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9442				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9442	
BIRTH NO. <u>Harve de Grace, Md.</u>				1. NAME OF DECEASED (Type or Print) <u>MARLENE SUE HOLCOMB</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>9-14-68</u> <u>12:34</u> P. M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND, HARFORD</u> B. COUNTY <u>62-00</u>			
				C. CITY OR TOWN <u>HAVRE DE GRACE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>Rt. # 1, Box 122</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-67</u>	9. AGE (In years lost birthday) <u>4-yr.</u>	If Under 1 Yr. Months: <u>9</u> Days: <u>25</u>	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Harve de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD HOLCOMB</u>				14. MOTHER'S MAIDEN NAME <u>SALLY BROWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mr. Richard Holcomb</u>		ADDRESS <u>Rt #1, Box 122</u>	
18. <u>273.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>PNEUMONIA - PSEUDOMONAS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CYSTIC FIBROSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u> <u>2 1/2 MONTHS</u>	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <u>289.3 II</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-26-68</u> to <u>9-14-68</u> , that (I) (we) last saw the deceased alive on <u>9-14-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Frank A Simon MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-14-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANK A. SIMON, M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/16/1968</u>		24C. NAME of CEMETERY or CREMATORY <u>Conowingo Baptist Cem.</u>		24D. LOCATION (City, town or county) (State) <u>Conowingo, Harford, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Censurston + Son, Harve de Grace, Md.</u>			



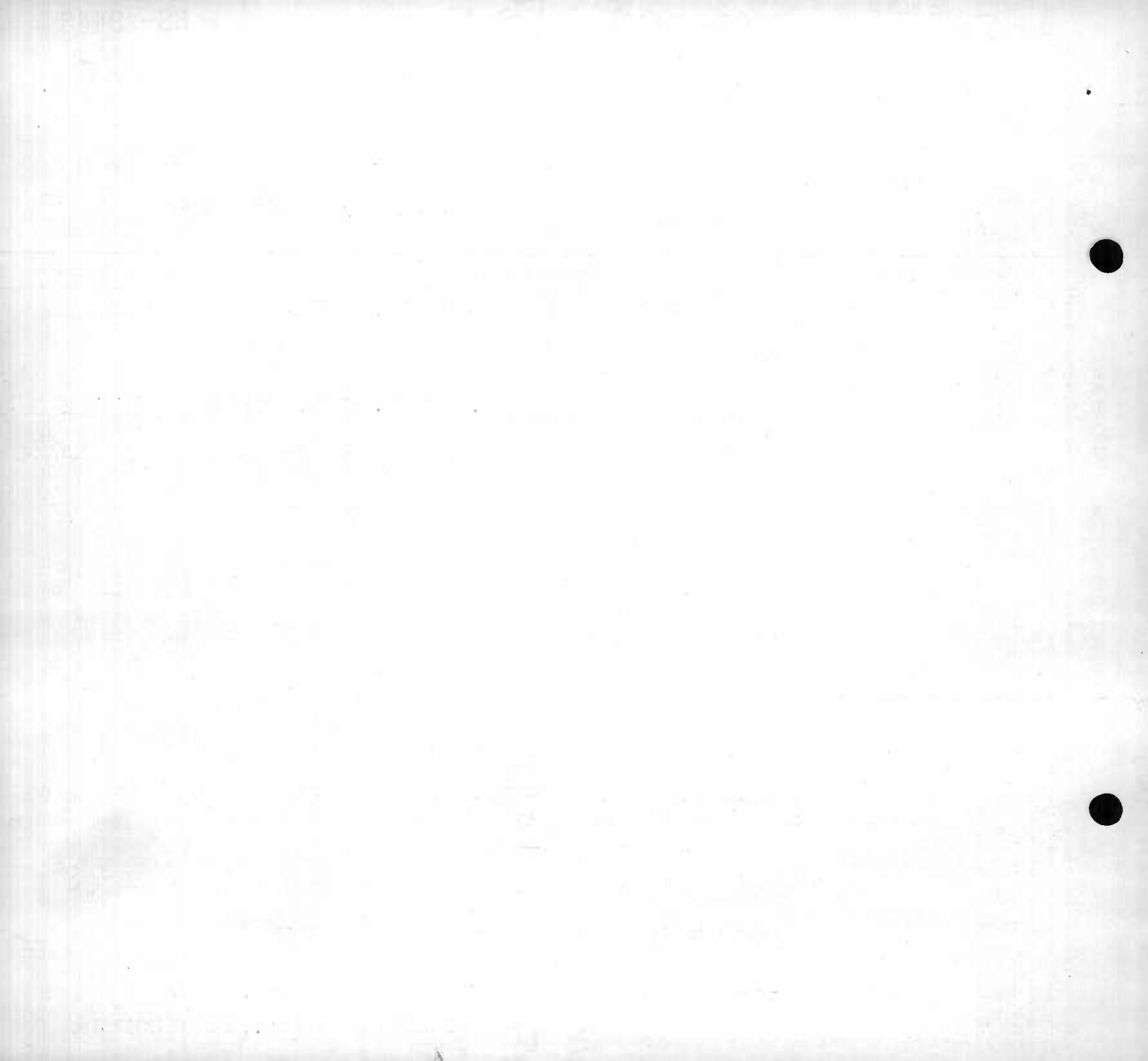
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9443 CERTIFICATE OF DEATH

REG. NO. **68- 9443**

BIRTH NO. 150		1. NAME OF DECEASED (Type or Print) BESSIE SIMON		2. DATE AND HOUR OF DEATH SEPTEMBER 14, 1968 7:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 5518 MINNOKA AVENUE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5 518 MINNOKA AVENUE #21215		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 24, 1908	9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME HARRY GUREVITZ			14. MOTHER'S MAIDEN NAME ELIZABETH ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. LOUIS N. SIMON, 5518 MINNOKA AVENUE #21215	
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of breast, metastatic 4 yrs.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 170 X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 12 19 68 to Sept 14 19 68 , that (I) (we) lost saw the deceased alive on Sept 12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Bakal				23B. DATE SIGNED 9-14-68	
23C. PHYSICIAN'S NAME (Type) DANIEL BAKAL		23D. ADDRESS 3600 LOCHEARN DRIVE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-15-68		24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968			
25B. NAME OF REGISTRAR R. L. S. Johnson		25C. FUNERAL DIRECTOR ADDRESS SOL KLEVINSON & BROS., 6010 REISTERSTOWN ROAD			



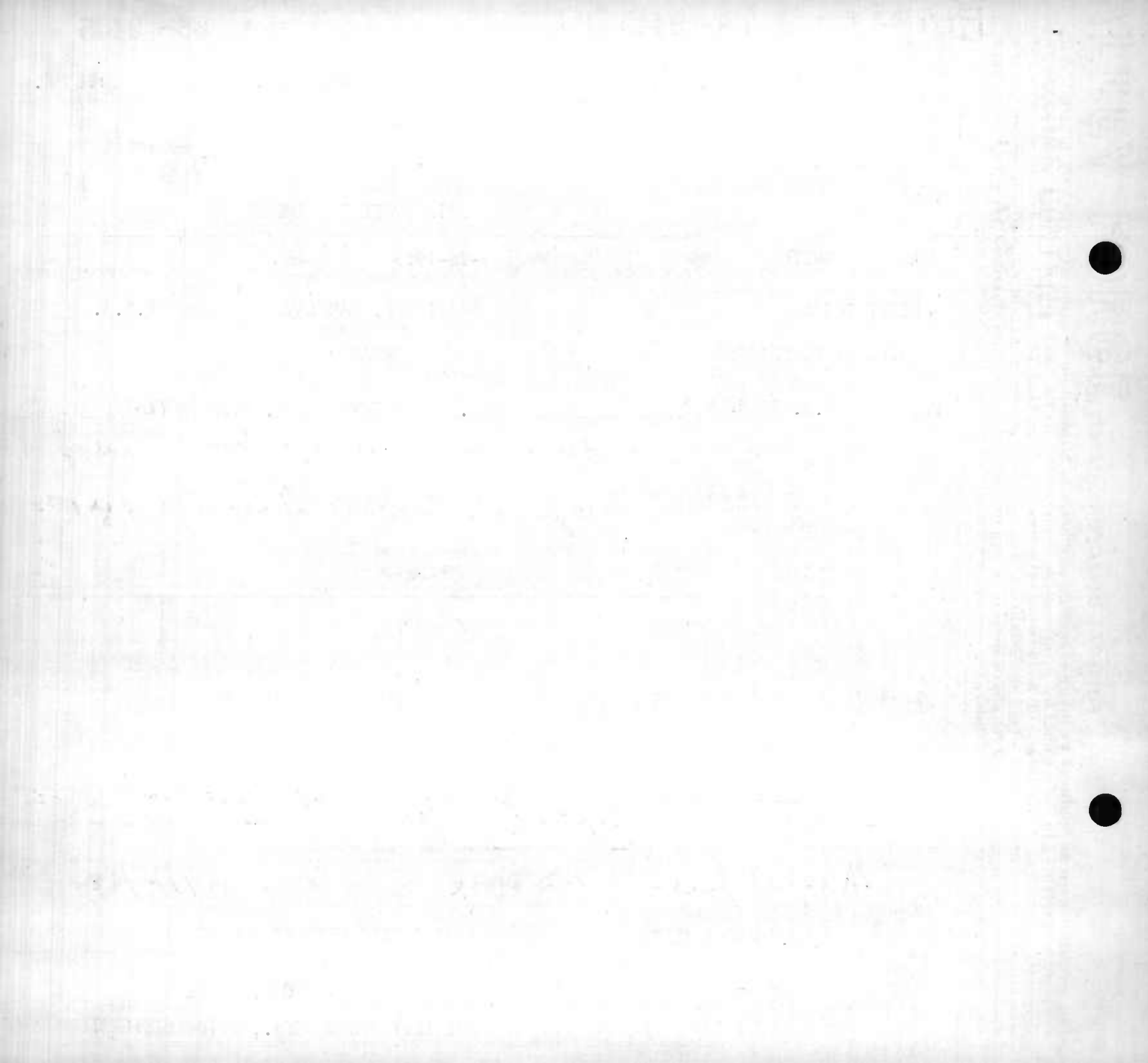
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9444
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ALEX SURASKY		September 14, 1968		1:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Belvedere Nursing Home 2525 W. Belvedere Avenue		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 4315 Forest Park Avenue					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 18, 1910	57	Display Director
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Hecht May Co.		Baltimore, Maryland		USA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
USA		Benjamin Surasky			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Late Anna Greenstein		No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		Mrs. Kay Surasky 4315 Forest Park Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 years	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
03 years				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 19 68 to Sept 12 1968, that (I) (we) lost saw the deceased alive on Sept 12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. Samuel Whitehouse M.D. DEGREE		Sept. 15/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Samuel Whitehouse		3000 N. Charles Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/15/1968		Chizuk Amuno W. Rogers Ave.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 17 1968		Sol Levinson & Bros.		6010 Reisterstown Rd.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

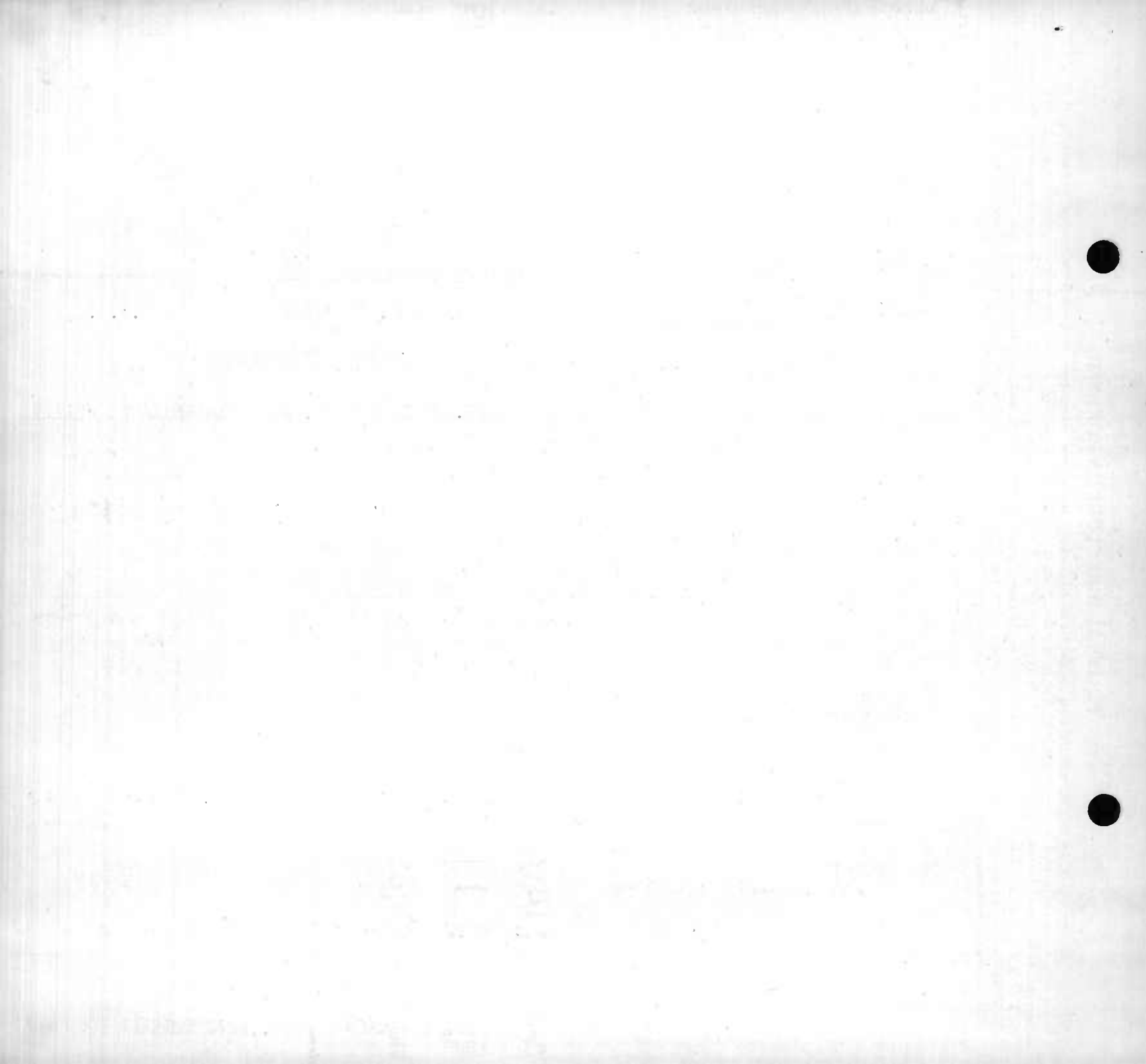
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9445	
BIRTH NO.		68- 9445		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		LOUIS FORSHLAGER		2. DATE AND HOUR OF DEATH SEPTEMBER 16, 1968 3:18 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3216 INGELSIDE AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-1923	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME MICHAEL FORSHLAGER		14. MOTHER'S MAIDEN NAME SARAH		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. IRENE FORSHLAGER, 3216 INGELSIDE AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/10/01 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Acute myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: none (C) none		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 42011 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 3, 1967 to Sept 16, 1968, that (I) (we) last saw the deceased alive on Sept 16, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel Levin		23B. DATE SIGNED 9/16/68		23C. PHYSICIAN'S NAME (Type) DR. MANUEL LEVIN	
23D. ADDRESS 6101 PARK HEIGHTS AVENUE		23E. ATTENDING PHYSICIAN Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-17-68		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. SEP 17 1968		24F. NAME OF REGISTRAR R. L. E. Fink	
24G. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		24H. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 9446
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH SEPTEMBER 16, 1968		6A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3308 CLARKS LANE 00		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3308 CLARKS LANE #21215			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 81	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ABRAHAM SCHEIN			
14. MOTHER'S MAIDEN NAME SARAH OPPENHEIM		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. JANE SHULMAN, 3308 CLARKS LANE #21215			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. </div> <div style="width: 45%;"> CAUSE OF DEATH Acute pulmonary edema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> <div style="width: 10%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years 15 years </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II Diabetes mellitus					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 15 1963 to SEPT 16 1968 that (I) (we) last saw the deceased alive on SEPT 16 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel Levin				23B. DATE SIGNED 9/16/68	
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN				23D. ADDRESS M.D. 6101 PARK HEIGHTS AVE BALTO-15 MO	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-17-68		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

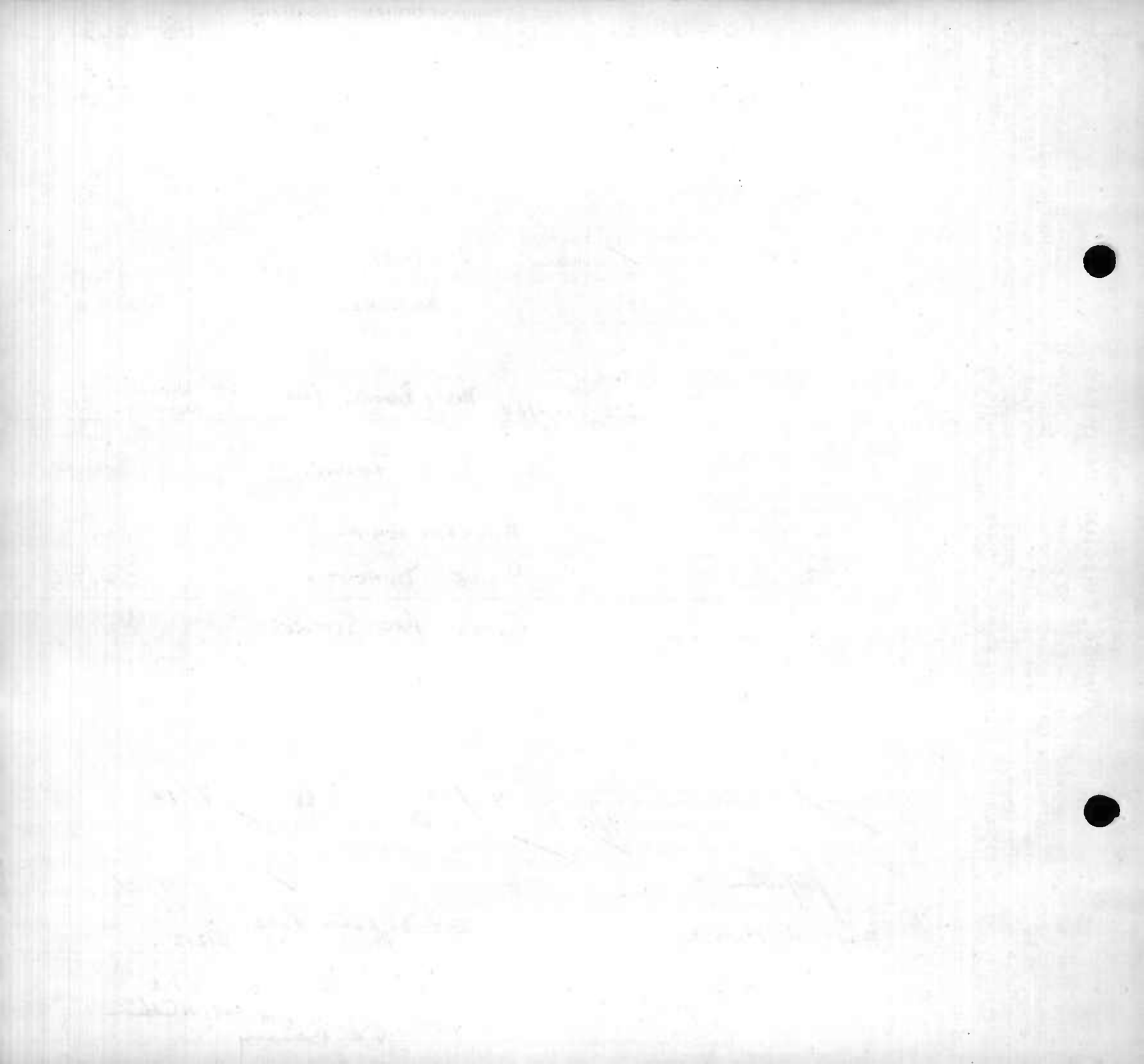
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9447

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 9447

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES. H. BROOKS.		2. DATE AND HOUR OF DEATH 14th Sept 1968. 2.15 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 21217		
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> No <input type="checkbox"/>	
5. SEX M		6. RACE Negro.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-24-89.		9. AGE (In years last birthday) 79		10. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) MARYLAND.		12. CITIZEN OF WHAT COUNTRY? AMERICA (U.S.A.)		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-4164	
17. INFORMANT HENRY BROOKS. (SON)		ADDRESS 1541 WOODYARD ST. BALTIMORE. 21217		18. 290.01 CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) RENAL FAILURE.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERKALAEMIA.				8 DAYS	
(B) DUE TO, OR AS A CONSEQUENCE OF: SENILE DEMENTIA				3 MONTHS.	
(C) GRAND MAL SEIZURES.				8 YRS.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 304X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 8/1/68 to 9/14/68 that (I) (we) last saw the deceased alive on 9/13/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 9/14/68.	
23C. PHYSICIAN'S NAME (Type) JOHN. H. MATHER.		23D. ADDRESS 5308-D. LEITH ROAD. BALT. MD. 21212.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-17-68		24C. NAME OF CEMETERY OR CREMATORY Wm. Aulburn Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR George G. YELSON. F.H. 1348, N. Calverton	

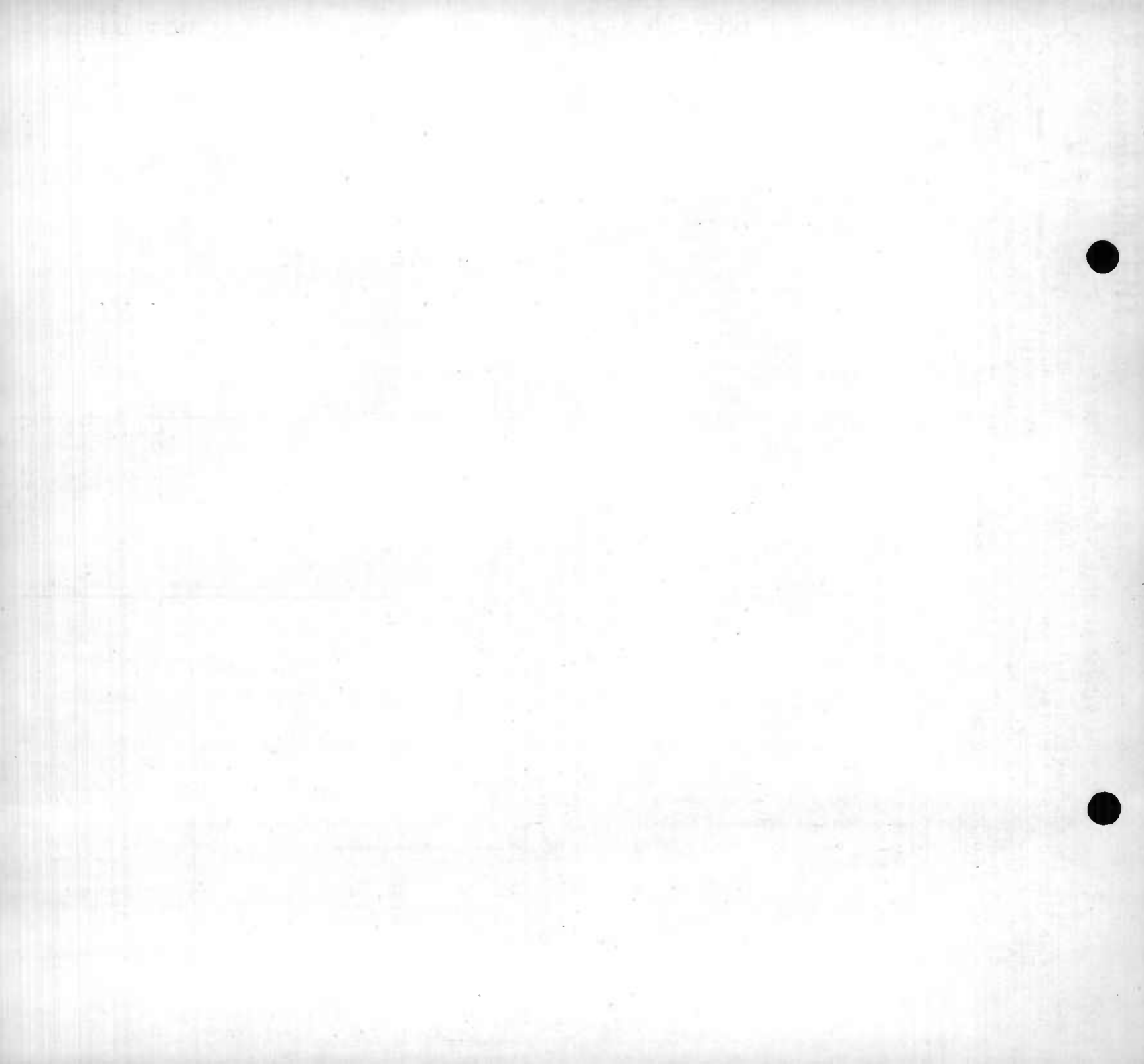


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9448 CERTIFICATE OF DEATH

REG. NO. 68- 9448

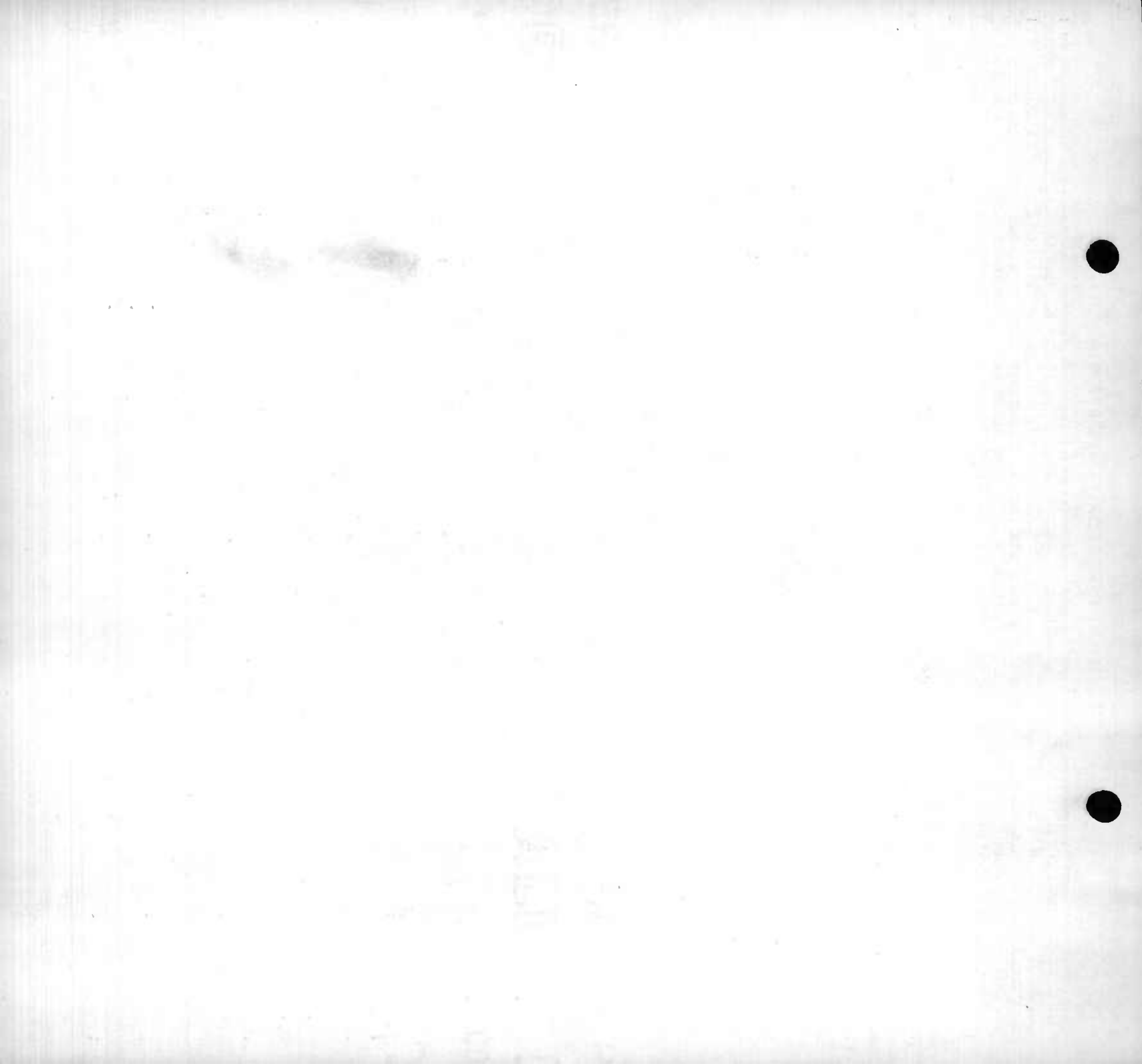
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		James G. Wilson		9-12-68 7 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Edgewood Nursing Home Belvedere & Bellona Ave. Baltimore, Maryland				A. STATE Md. B. COUNTY	
				C. CITY OR TOWN Balto.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1146 N. Carey St.	
5. SEX Male	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-23-78	9. AGE (In years last birthday) 90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Wilson				14. MOTHER'S MAIDEN NAME Rosetta Jones	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Nettie Millier 1824 Mount St.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction (B) Atherosclerotic cardiovascular (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr 5+ yr	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 6, 1968 to Sept 12, 1968, that (I) (we) last saw the deceased alive on Sept 12, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer MD				23B. DATE SIGNED 9-13-68	
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER MD				23D. ADDRESS 6100 York Rd Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-16-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR V.R. Bailey Kelson F.H. 1348 N. Calhoun Street	



41-75-461
CEK

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-200		BALTIMORE CITY HEALTH DEPARTMENT 68- 9449 CERTIFICATE OF DEATH		REG. NO. 68- 9449	
1. NAME OF DECEASED (Type or Print) <u>DOROTHY M. ROSS</u>			2. DATE AND HOUR OF DEATH <u>9-12-68</u> <u>5:00</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/> E. STREET AND NUMBER <u>1227 POPLAR GROVE STREET #21216</u>		
5. SEX <u>Female</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-04</u>	9. AGE (In years lost birthday) <u>63</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>RECORDS: 4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u>
18. <u>203X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MULTIPLE MYELOMA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u> <u>4 years</u> <u>11 hours</u>
19. <u>203X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			<u>PULMONARY EDEMA</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>SEPT 8</u> 19 <u>68</u> to <u>SEPT 12</u> 19 <u>68</u> , that (2) (we) last saw the deceased alive on <u>SEPT 12</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Daniel C. Hadlock MD</u>			23B. DATE SIGNED <u>9-12-68</u>		23C. PHYSICIAN'S NAME (Type) <u>DANIEL C. HADLOCK</u>
23D. ADDRESS <u>4940 EASTERN AVENUE, BALTO., MD. #21224</u>			23E. <u>BALTIMORE CITY HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-16-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>V.R. Bailey</u>		25D. ADDRESS <u>Kelson F.H. 1348 N. Calhoun St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9450 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9450

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Florence Cassie Cole

2. DATE AND HOUR OF DEATH

9-14-68

8 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2305 Reisterstown Rd.
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2305 Reisterstown Rd.

5. SEX

Female

6. RACE

Negroid

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

4-25-74

9. AGE (In years last birthday)

94

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

231540366

17. INFORMANT

Margaret Thomas

ADDRESS

same

18.

440.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Generalized Arteriosclerosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

SENILITY

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

450.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/14/68 to 9/14/68, that (I) (we) last saw the deceased alive on 9/14/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Albert L. Bankfield

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

9/16/68

23C. PHYSICIAN'S NAME (Type)

G. L. BANKFIELD, M.D.

23D. ADDRESS

722 N. Fulton Ave. Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-18-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

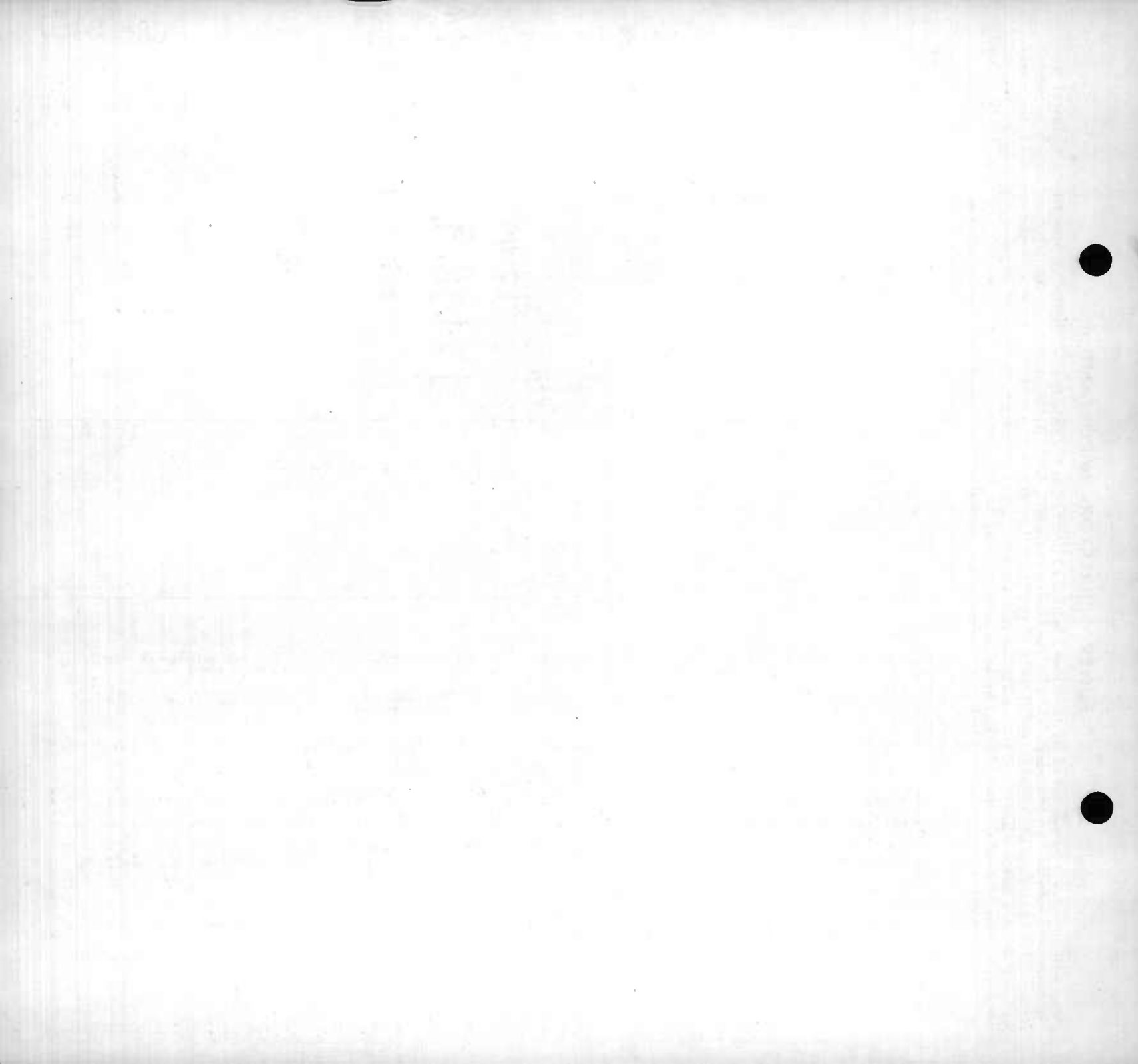
25C. FUNERAL DIRECTOR

V.R. Bailey

ADDRESS

Kelson F. H. 1348 N. Calhoun Street

SEP 17 1968



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-9451

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ARETHA MOODY (Arietha)

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

September 14, 1968

9:05 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

00628 Round View Road (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 14, 1968

9:05 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒No ☐

9. DATE OF BIRTH

5-2-52

10. AGE (In years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3208 Cherryland Road

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Moody Sr.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Maisie Horsey

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

none

18. INFORMANT

William Moody Sr.

ADDRESS

same

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Shotgun wound of head

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

House

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

628 Roundview Road

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

Sept. 14, 1968 9:00 P.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shotgun wound of head

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 15, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-19-68

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 17 1968

25B. NAME OF REGISTRAR

R. E. E. Jackson

25C. FUNERAL DIRECTOR V.R. Bailey

Kelson F. H. 1348 N. Calhoun St.

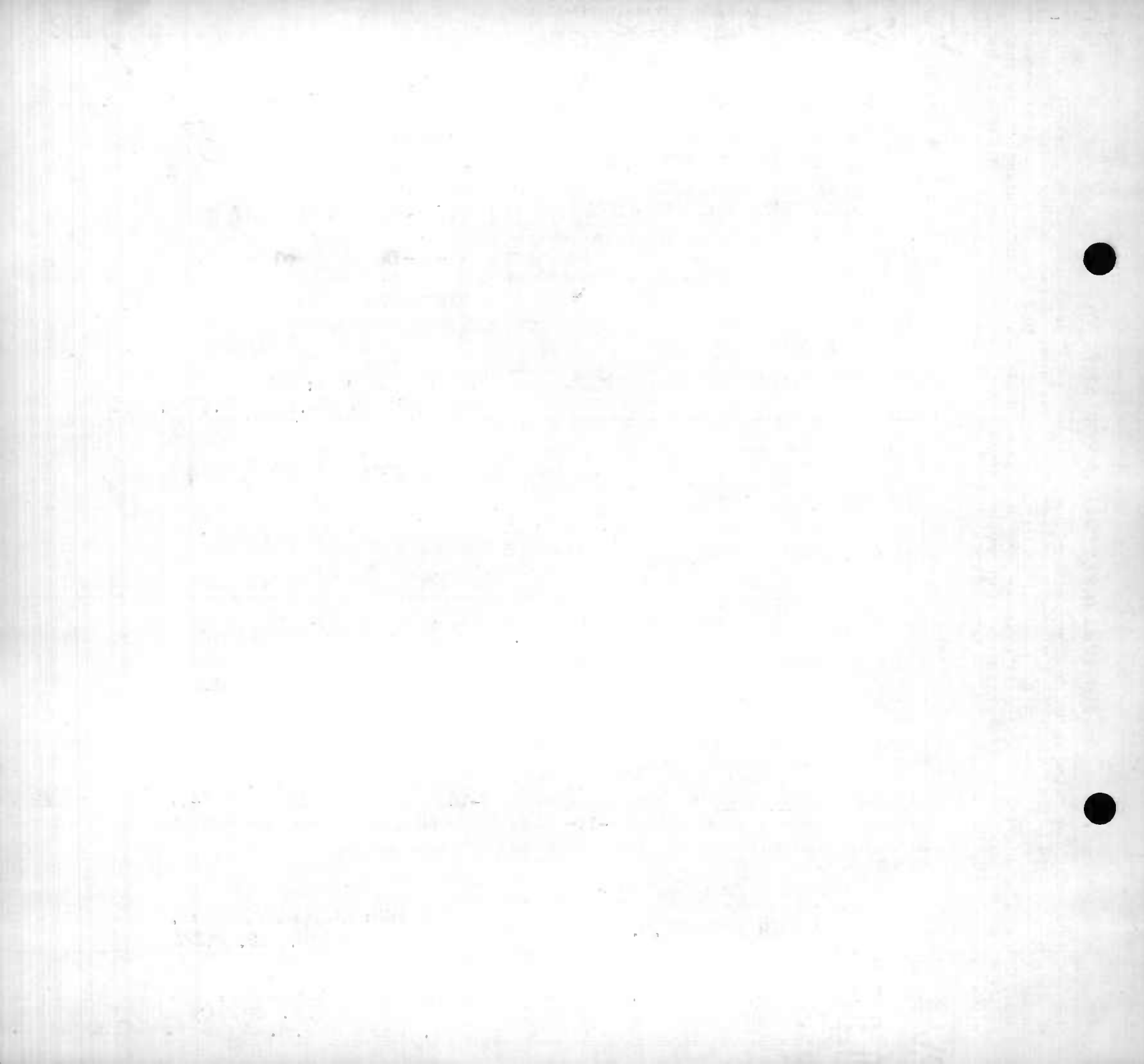
WALLS 1000000

2000000

X

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

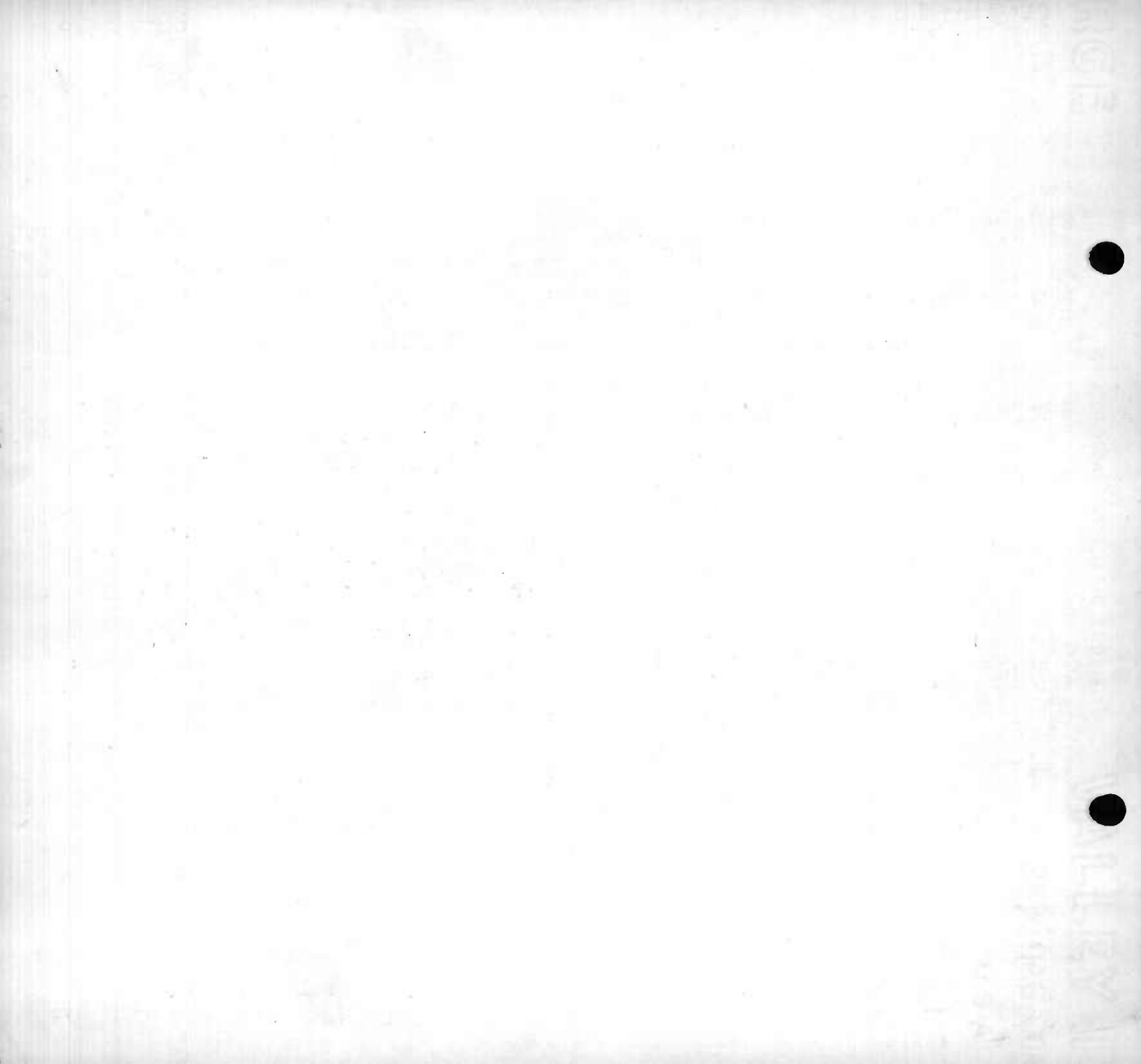
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9452	
BIRTH NO. R-263		68- 9452		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) NANNIE RICHARDSON		2. DATE AND HOUR OF DEATH 9/11/68 11:05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND		B. COUNTY	
31		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 715 BAKER STREET 21217			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-06	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME ARMSTEAD Lacy		14. MOTHER'S MAIDEN NAME MARIA H		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS, BCH ADDRESS 4940 EASTERN AVE., BALTO., MD. 21224	
18. 590.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE		8 WKS.	
		(B) ACUTE PYELONEPHRITIS DUE TO, OR AS A CONSEQUENCE OF:			
		(C) 2 CHRONIC PYELONEPHR			
600.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CONGESTIVE HEART FAILURE			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-18 19 68 to 9-11 19 68, that (I) (we) last saw the deceased alive on 9-11- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Kaplan M.D.				23B. DATE SIGNED 9/11/68	
23C. PHYSICIAN'S NAME (Type) JOSEPH KAPLAN M.D.				23D. ADDRESS BCH: 4940 EASTERN AVE. BALTO., MD. 21224	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9-14-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR Robert E. Finkbeiner		24F. FUNERAL DIRECTOR V.R. Bailey	
24G. DATE REC'D BY HEALTH DEPT. SEP 17 1968		24H. NAME OF REGISTRAR		24I. ADDRESS Geo. Kelson F.H. 1348 N. Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9453
BIRTH NO. 50		68- 9453 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) JAMES LOGAN		2. DATE AND HOUR OF DEATH Sep 15/68 5:00P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 Md Genl. Hosp		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 11-03		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md Genl. Hosp		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 443 Orchard Street		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/09	9. AGE (in years lost birth) 59
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Chemical Plant		11. BIRTHPLACE (State or foreign country) South Carolina
13. FATHER'S NAME Frank Logan		14. MOTHER'S MAIDEN NAME Elizabeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr Ben Logan
				ADDRESS 2004 Poplar
18. 34521 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Branchiopneumonia		CAUSE OF DEATH Branchiopneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Anoxia 2° to status epilepticus		
		(B) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:		
		(C) Myocarditis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 353.2 II				
19A. DATE OF OPERATION 9/15/68	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 9/11/68 to 5:00AM 9/15/68 , that (I) (we) last saw the deceased alive on 9/15/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE A S GLUSHAKOW		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) A S GLUSHAKOW		23D. ADDRESS Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/20/68	24C. NAME OF CEMETERY or CREMATORY M. Auburn Cemetry	24D. LOCATION (City, town, or county) (State) Baltimore M.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968	25B. NAME OF REGISTRAR Robert E. ...	25C. FUNERAL DIRECTOR A Halstead 1206 W North Ave		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9454

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM A MILLER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 14, 1968 8:50 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOPKINS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 14, 1968 8:50 P. M.	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 11-11-1945		10. AGE (In years last birthday) 22	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 2213 E. Pratt Street
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME ALMA J. MOORE
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212 46 9487	18. INFORMANT ADDRESS Mrs. Alma J. Moore - 2340 E. Fayette St.

19. E 966 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH Stab wound of Heart		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
	(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E 982 X II			

20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 41 N. Patterson Park Avenue
22D. TIME (Month) (Day) (Hour) (Minute) OF INJURY (APPROX.) Sept. 14, 1968 8:45 P.M.	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Stabbed during altercation

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> September 15, 1968	

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-18-68	24C. NAME OF CEMETERY or CREMATORY MT. CARMEL Cem	24D. LOCATION (City, town, or county) (State) BALTO., Md.
---	-----------------------------	---	---

25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968	25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR Walter Hill	ADDRESS - 2334 Jefferson St.
---	--	---	--

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-4210		68- 9455		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 9455	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) NANNIE WILLIS			2. DATE AND HOUR OF DEATH 9 / 15 / 68 6:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? 15 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1634 N. Monroe St.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-90		9. AGE (In years lost birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Talbot CO. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Gross				14. MOTHER'S MAIDEN NAME Annie Moody			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-16-6030		17. INFORMANT Ellen Bevens		ADDRESS 602 Radnor Avenue	
18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C. V. A.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/31/68 to 9/15/68 , that (I) (we) lost saw the deceased alive on 9/15/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. S. Ming				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/15/68	
23C. PHYSICIAN'S NAME (Type) CHEE SHWE MING				23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/68		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore CO. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Herbert B. Nutter 3035 W. North Ave.			

FUNERAL DIRECTOR: IMPORTANT

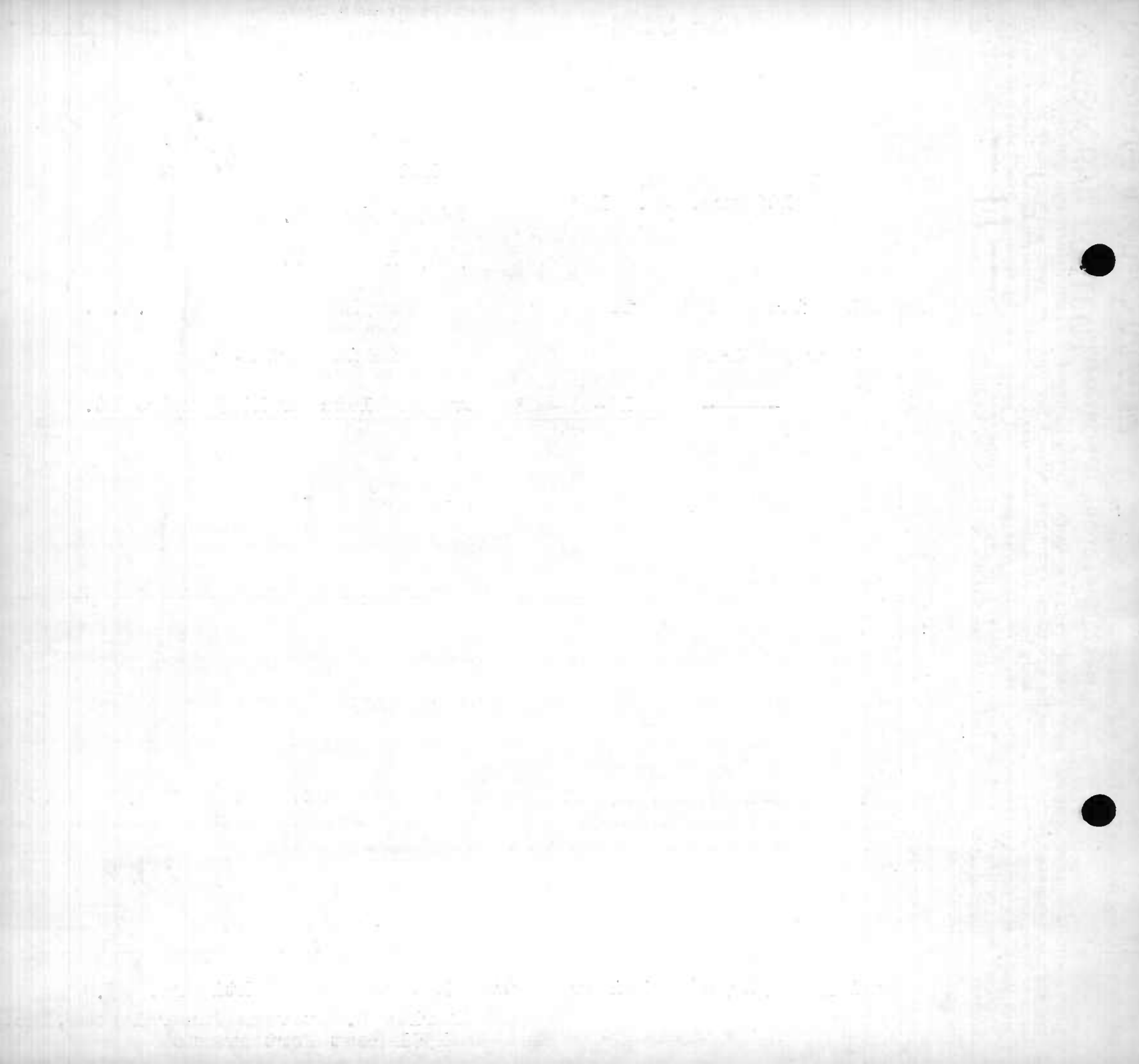
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9456 CERTIFICATE OF DEATH

REG. NO.

68- 9456

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Bessie M. Rooney		2. DATE AND HOUR OF DEATH 9/15/68		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY	
00		1439 Andre St. Baltimore, Md. 21230		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1439 Andre St.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/27/91		9. AGE (in years lost birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly Line		10B. KIND OF BUSINESS OR INDUSTRY Columbia Paper		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Clark				14. MOTHER'S MAIDEN NAME Minnie Bridner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-8234		17. INFORMANT ADDRESS Evelyn Fletcher 1435 Andre St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.91 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) arteriosclerotic cardiac ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: vascular disease (B) senile arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 17 19 68 to Sept 7 19 68 , that (I) (we) last saw the deceased alive on Sept 7 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.							
23A. SIGNATURE Romulo V. Goco				23B. DATE SIGNED 9/16/68		23C. PHYSICIAN'S NAME (Type) Romulo V. Goco M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.		ADDRESS 1501 East Fort Avenue	



FUNERAL DIRECTOR: IMPORTANT

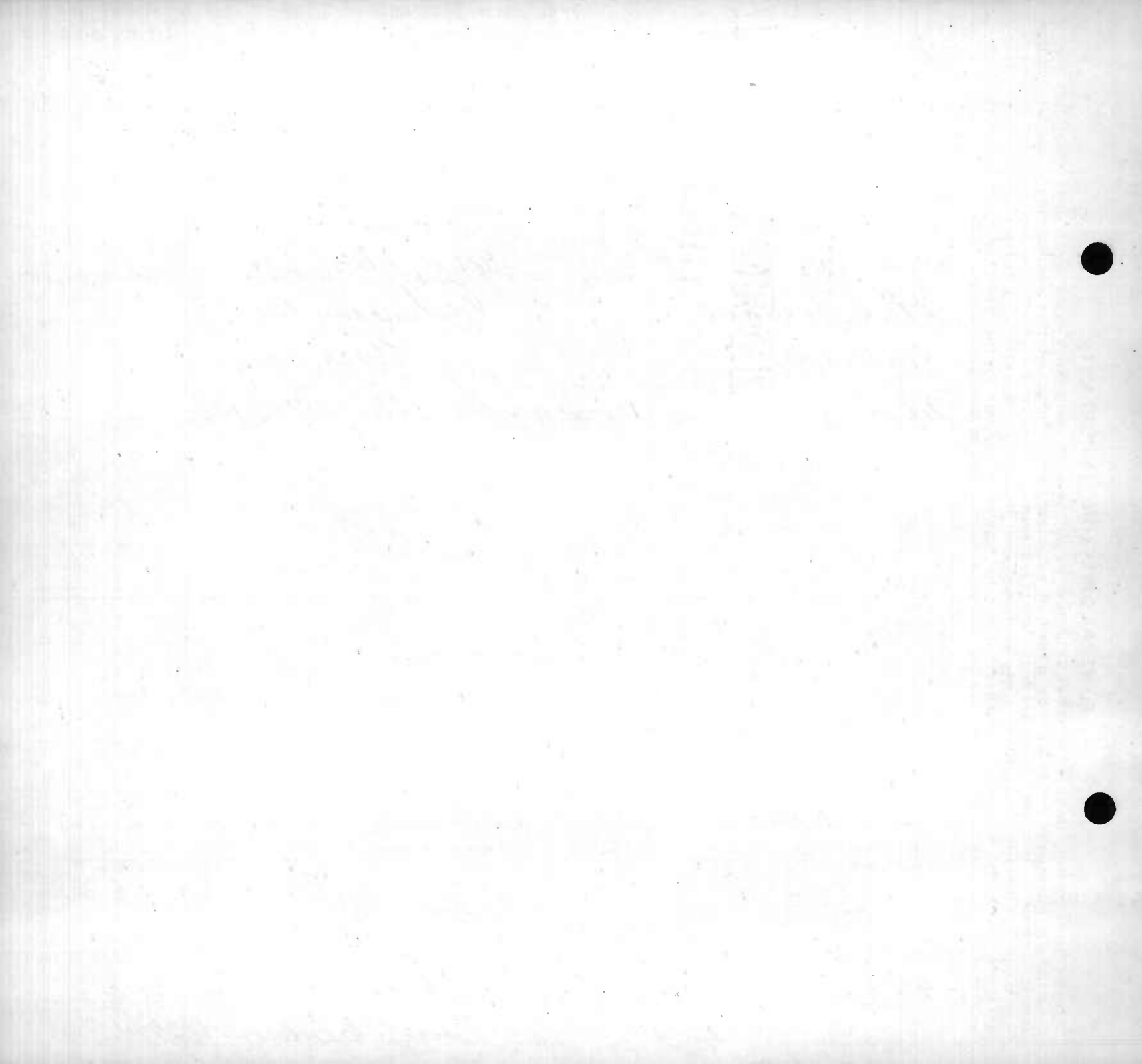
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9457 CERTIFICATE OF DEATH

REG. NO. 68- 9457

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANK COSBY		2. DATE AND HOUR OF DEATH SEPT. 15, 1968 9:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 15-11	
FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3700 Cedarvale Road		8. DATE OF BIRTH Oct 10, 1903		9. AGE (In years last birthday) 64	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Richmond, Va.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 137-16-9806		17. INFORMANT Brother Cosby	
18. 4339 I		CAUSE OF DEATH		ADDRESS 3700 Cedarvale Rd	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CEREBRAL THROMBOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 Mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF:			
(C) ARTERIOSCLEROTIC HEART DISEASE					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 7-23 1968 to 9-15 1968 , that (H) (we) lost saw the deceased alive on 9-15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irving L. Cooperstein				23B. DATE SIGNED 9-15-68	
23C. PHYSICIAN'S NAME (Type) IRVING L. COOPERSTEIN				23D. ADDRESS MONTEBELLO HOSP., BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE SEP 17 1968		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial	
24D. LOCATION (City, town, or county) (State) Arbutus, Md		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Joseph E. Johnson		25D. ADDRESS 1129 N. Calhoun St			

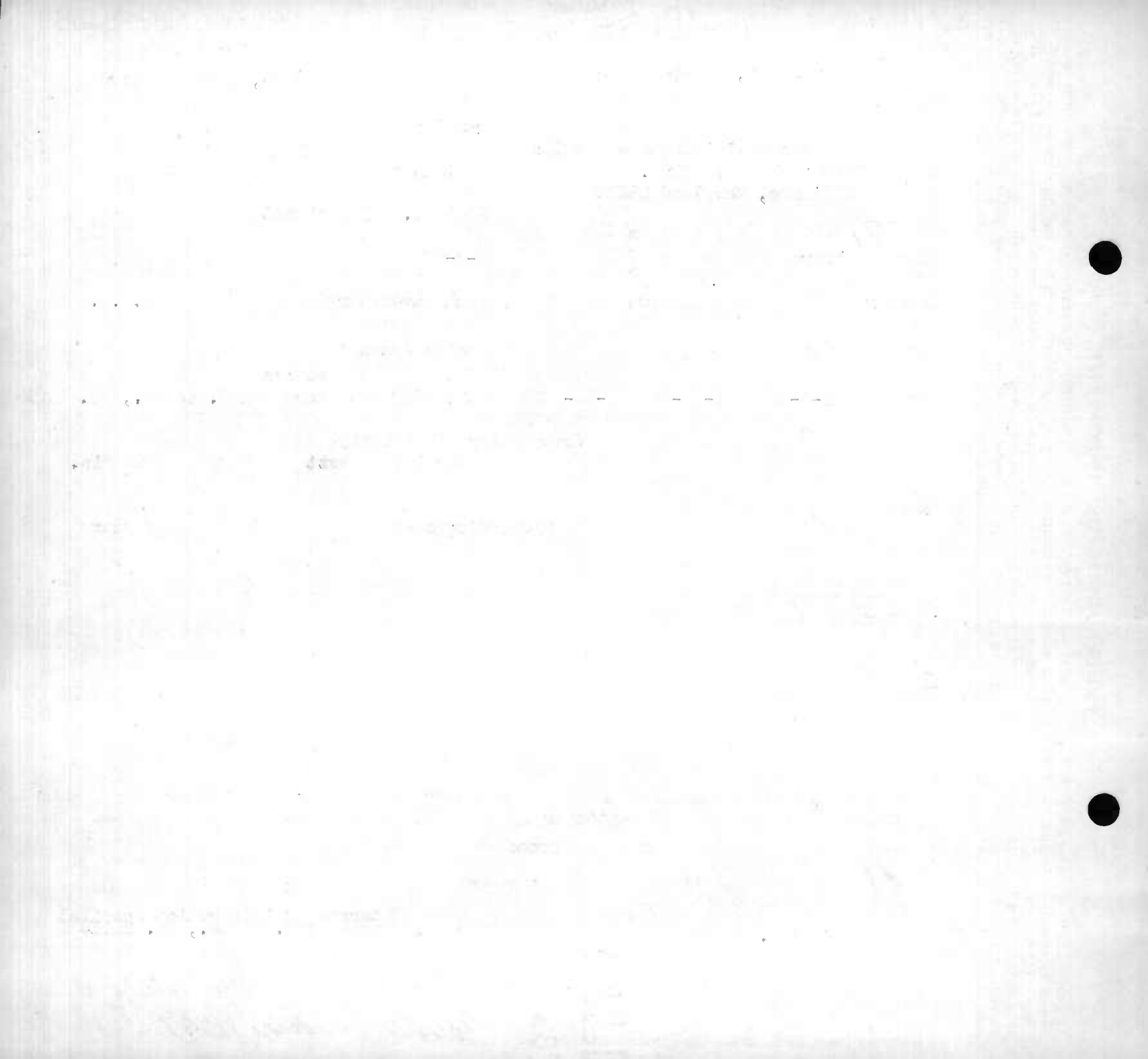


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9458 CERTIFICATE OF DEATH

REG. NO. 68- 9458

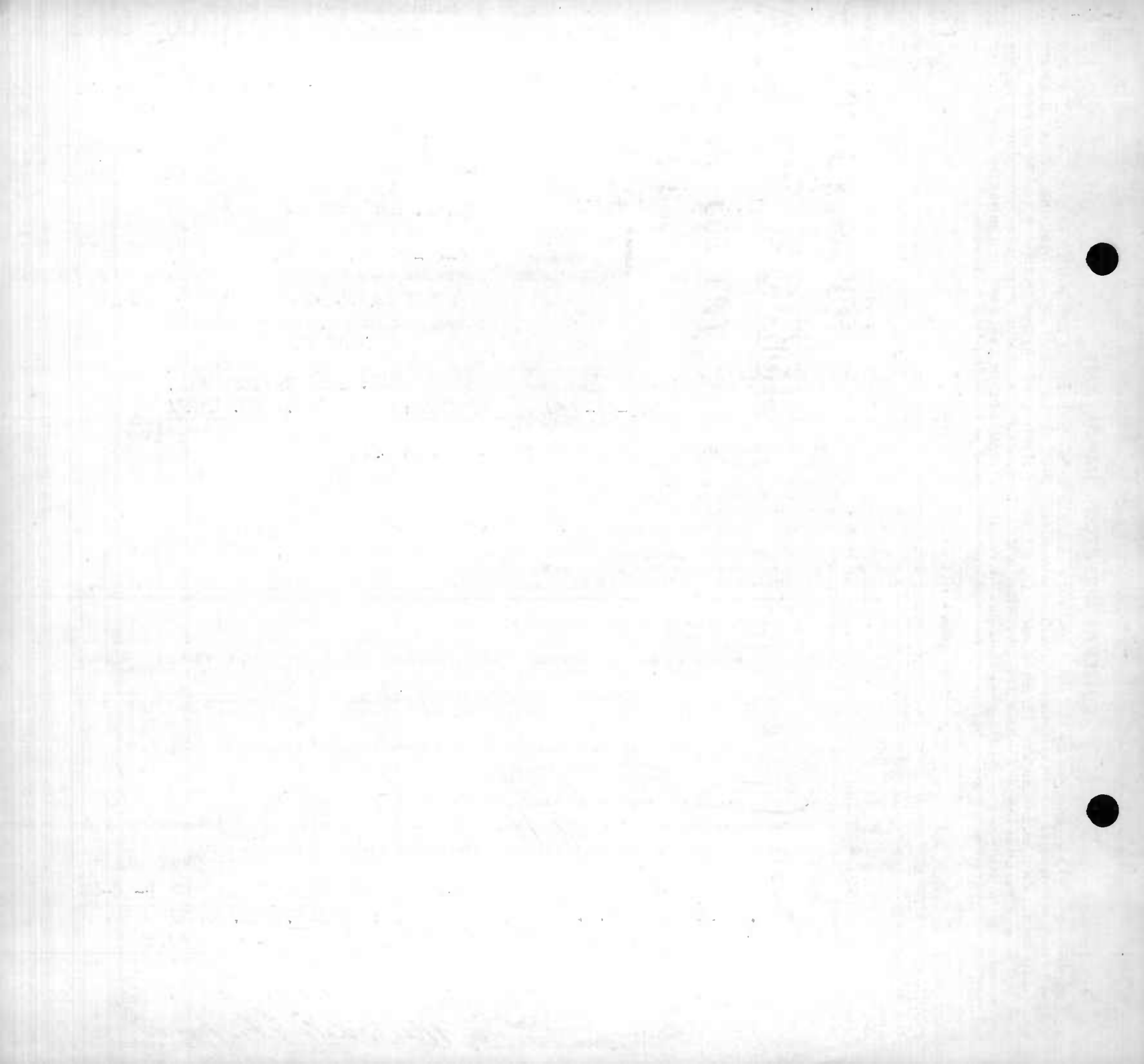
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HARVEY, Calvin Isaac		2. DATE AND HOUR OF DEATH September 13, 1968 1:00A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF 106A) HOSPITAL 23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5-9-20		9. AGE (In years last birthday) 48		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Loch Raven Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Harvey		14. MOTHER'S MAIDEN NAME Arelis Ayers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-9-42 to 1-11-46		16. SOCIAL SECURITY NO. 212-16-3204		17. INFORMANT Records ADDRESS VAH, 3900 Loch Raven Blvd. Balto., Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 425 X1 Ventricular Fibrillation Cardiac Arrest		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardiology		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 Min. 5 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 433.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from September 10 19 68 to September 13 19 68 , that (2) (we) last saw the deceased alive on September 13 19 68 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) not view the body after death.			
23A. SIGNATURE Hewes D. Agnew		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Hewes D. Agnew	
23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd. Balto., Md. 21218		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE Sep. 18/68		24C. NAME OF CEMETERY or CREMATORY Balto. Natl Cem	
24D. LOCATION 5501 Fredrick Ave		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR SEP 17 1968	
24G. NAME OF REGISTRAR SEP 17 1968		24H. FUNERAL DIRECTOR 1129 N. Calhoun St		24I. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

50-53-61 VLB		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9459	
BIRTH NO. 152		68-9459		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) PAUL SPENCE			2. DATE AND HOUR OF DEATH 11:45 AM 9/10/68 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 731 N. EDEN STREET 21205					
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-08	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EDWARD		14. MOTHER'S MAIDEN NAME MARY MERCY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-01-5994		17. INFORMANT BCH: 4940 EASTERN AVE. RECORDS: BALTO., MD. 21224	
18. 192.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH ? pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASTROCYTOMA (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 + year	
193.9 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/67 to 9/10/68, that (I) (we) last saw the deceased alive on 9/10/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lee J. Cordova M.D. LEE J. CORDOVA M.D.				23B. DATE SIGNED 9-10-68	
23C. PHYSICIAN'S NAME (Type) LEE J. CORDOVA M.D.				23D. ADDRESS BCH: BALTO., MD. 21224 4940 Eastern Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE SEP 17 1968		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem	
24D. LOCATION (City, town, or county) (State) A.A. County Md		24E. DATE REC'D BY HEALTH DEPT. SEP 17 1968		24F. NAME OF REGISTRAR Robert E. Jackson	
24G. FUNERAL DIRECTOR Melton E. Elchman		24H. ADDRESS 1154 N. Carroll St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

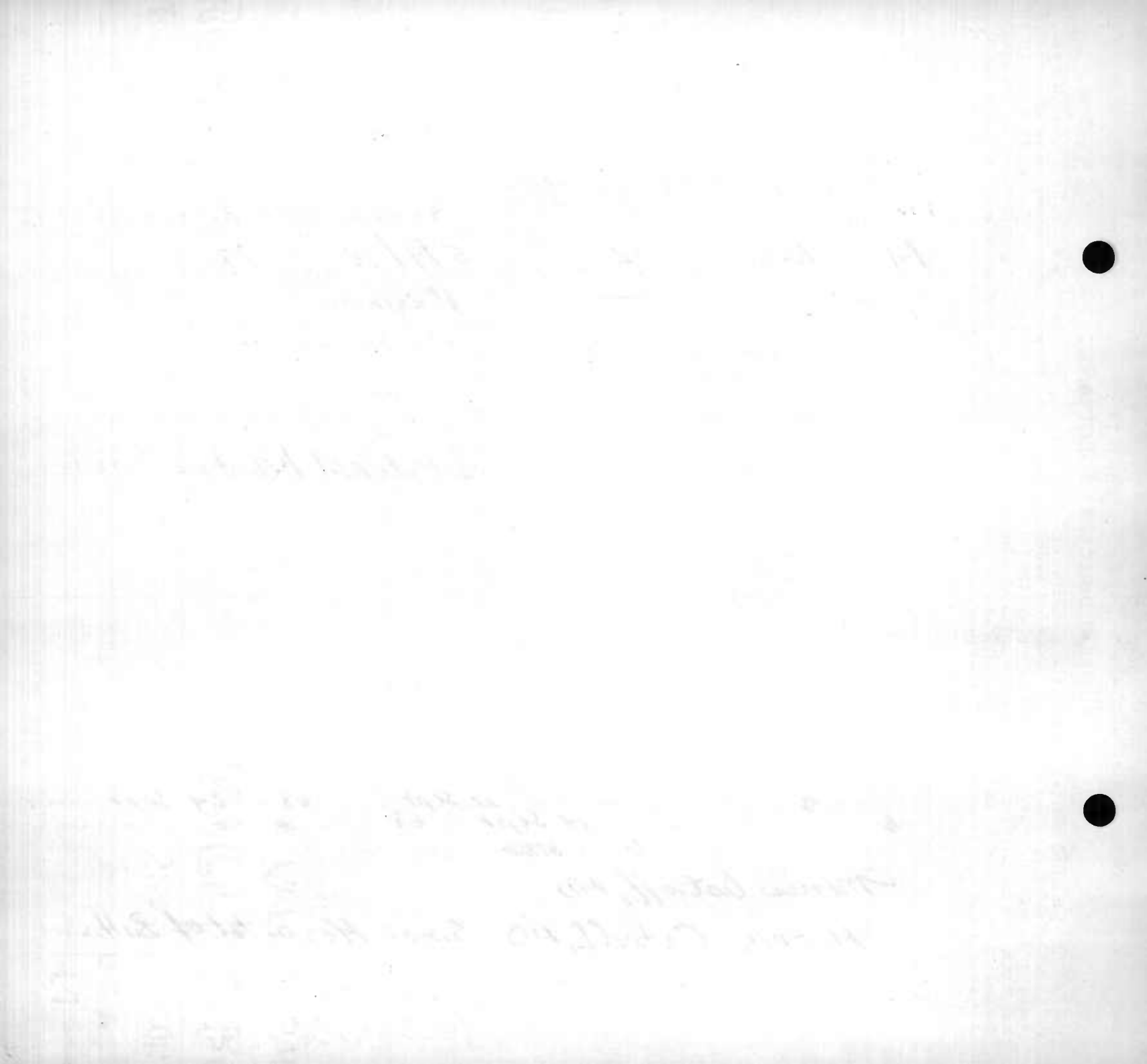
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9460			
1. NAME OF DECEASED (Type or Print) ELIZABETH SYKES				2. DATE AND HOUR OF DEATH 9/14/68 12:45 A M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital				A. STATE MARYLAND B. COUNTY 8				C. CITY OR TOWN Baltimore INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 3612 E. Federal St.							
5. SEX Female	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-17	9. AGE (In years last birthday) 50 51	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Petersburg, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME NATHANIEL PARHAM				14. MOTHER'S MAIDEN NAME MARY COOPER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE				17. INFORMANT Freddie R. Sykes			
				ADDRESS 2612 E. Federal St.							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4463 X I				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uremia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 4466 X II				(B) DUE TO, OR AS A CONSEQUENCE OF: Nephrosclerosis				72 years			
				(C) Hypertension				10-15 years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from August 12 19 68 to Sept 14 19 68 , that (I) (we) last saw the deceased alive on Sept 13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE David A. Bass								23B. DATE SIGNED 9/14/68			
23C. PHYSICIAN'S NAME (Type) DAVID A. BASS								23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-17-68		24C. NAME OF CEMETERY or CREMATORY N. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Randolph J. Collick		25D. ADDRESS 2431 E. Oliver St.					

SEP 17 1968

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.				68- 9461			
1. NAME OF DECEASED (Type or Print) <i>John F. Willis</i>				2. DATE AND HOUR OF DEATH <i>14 Sept 1968 2²⁴ P.M.</i>											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>											
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital of Baltimore</i>				C. CITY OR TOWN <i>Baltimore Md.</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
E. STREET AND NUMBER <i>3535 Washburn Avenue 21215</i>															
5. SEX <i>M</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/9/90</i>		9. AGE (In years lost birthday) <i>78</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (State or foreign country) <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Joseph Willis</i>				14. MOTHER'S MAIDEN NAME <i>Lucy Browne</i>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Lucy Willis</i>				ADDRESS <i>3535 Washburn</i>			
18. <i>4319 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Subdural hematoma</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).															
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>Yes</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that the (this hospital) attended the deceased from <i>13 Sept 1968</i> to <i>14 Sept 1968</i> , that the (we) last saw the deceased alive on <i>14 Sept 1968</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. My (We) (did) not view the body after death.															
23A. SIGNATURE <i>Morris Ostroff, MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED							
23C. PHYSICIAN'S NAME (Type) <i>MORRIS Ostroff, MD</i>				23D. ADDRESS <i>Sinai Hospital of Baltimore</i>											
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>9-17-68</i>				24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Ch. Baltimore Md.</i>				24D. LOCATION (City, town, or county) (State) <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 17 1968</i>				25B. NAME OF REGISTRAR <i>Robert E. Farber</i>				25C. FUNERAL DIRECTOR <i>Wilmington Phillips</i>				ADDRESS <i>1727 N. Mount St</i>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9462

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES ODEN

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

7:07 a M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

7:07 a M.

September 11, 1968

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Male

7. RACE

Colored

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

Aug. 17, 01

10. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2749 Booker T. Drive

11. BIRTH PLACE (State or foreign country)

Newton, Miss

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WII

17. SOCIAL
SECURITY NO.

214-14-3629

18. INFORMANT

Mrs. Lousie Oden

ADDRESS

2749 Booker Drive

19. 4124

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Sept. 11, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

9-11-68

24C. NAME of CEMETERY or CREMATORY

LOU DON PARK

24D. LOCATION (City, town, or county)

BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.

SEP 17 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

ADDRESS

Arlington S. Phillips 1727 N. Monroe Street

1
w-100

68- 9463 BALTIMORE CITY HEALTH DEPARTMENT

68- 9463

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MABEL WEBB

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 8, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)39
79
CERTIFICATE AMENDED - 10/1/68
Provident Hospital (DOA)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 8, 1968

7:32 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

3-16-21

10. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2313 Eutaw Place

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William H. Lee

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Wife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Katie Jeffers

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Handy Webb

ADDRESS

2313 Eutaw Place

19. 4319 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Intracranial hemorrhage
DUE TO, OR AS A CONSEQUENCE OF:

Ruptured saccular aneurysm

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

3318 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 9, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-10-68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 17 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

ADDRESS

Arlington S. Phillips 1727 N. Monroe Street

10/10/68 - Letter from Dr. Charles S.
Springate, Assistant Medical Examiner.
Date: 10/10/68.

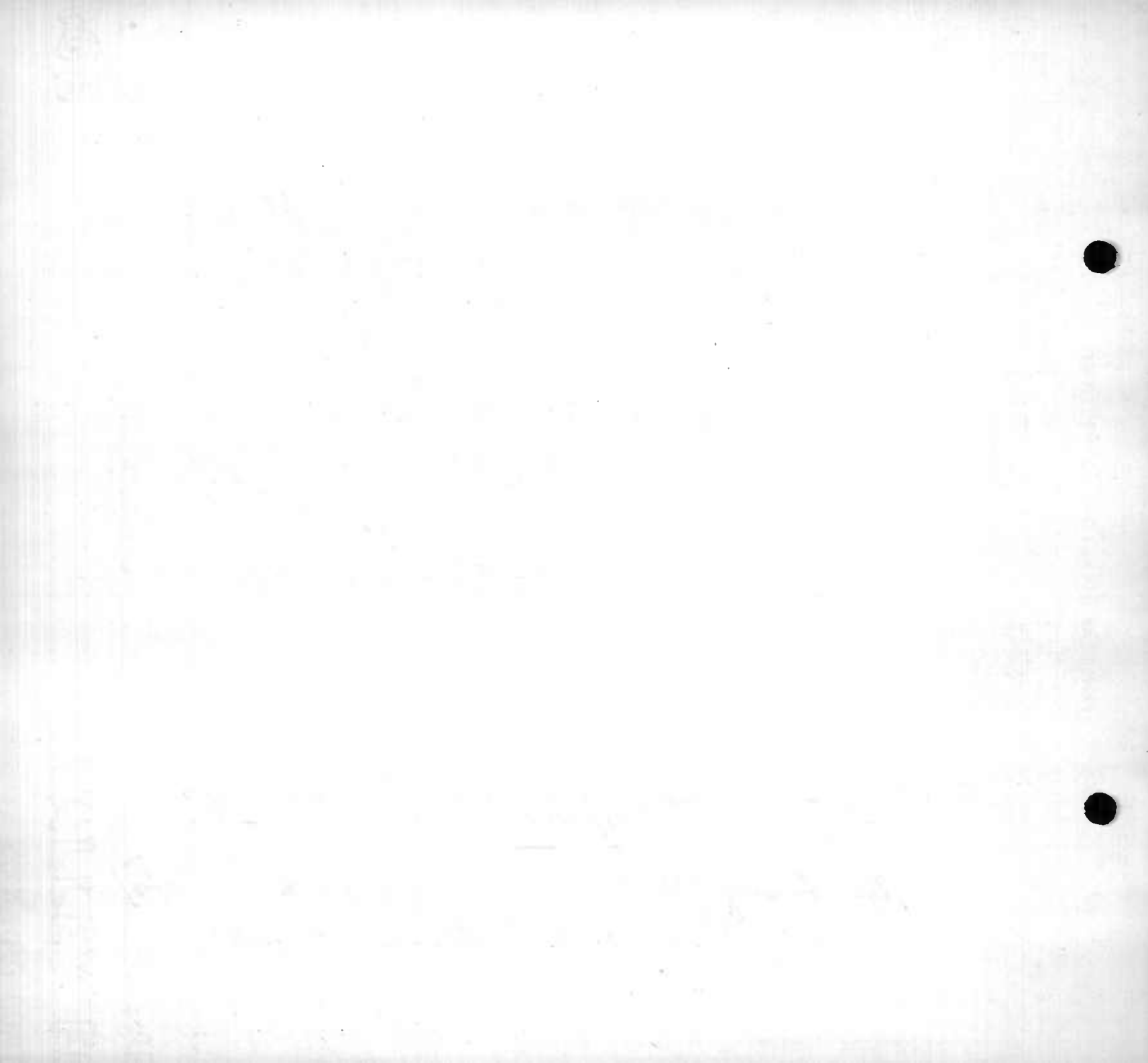
VALLEY FORCE

25% RAC CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. — 68- 9464	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DELORES KING (Rosalee)		9/9/68 9:20 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
42		SINAI HOSPITAL OF BALTIMORE		Maryland 13-04	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2216 Bryant Ave.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday)
F	N	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-19-1920		48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House wife				Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John W. Bowman		Laura Dailey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		214-14-2112		William H. King Same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made at dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				48 hr.	
ANTECEDENT CAUSES				few days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				8 mo	
456X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from 9/8 1968 to 9/9 1968, that (I) (we) lost saw the deceased alive on 9/9/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE, SIGNED	
Abe Levy, M.D.				9/9/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ABE LEVY, M.D.				Sinai Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-13-68		Mt. Auburn Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 17 1968		Robert E. Johnson		Wilmington Shillips 5782 1/2 St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 9465

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HAYES HATTIE		2. DATE AND HOUR OF DEATH 9/7/68 - 1:40 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1/6 LUTHERAN HOSPITAL OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3111 Harlow Avenue	
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1897	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Farm Helper		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Ernest Hayes			14. MOTHER'S MAIDEN NAME Louise Williams		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Daughter	
				ADDRESS 2715 Harlow Avenue	
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardio respiratory failure and arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 450.0 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/6/68 to 9/7/68 , that (I) (we) last saw the deceased alive on 9-7-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Mathiprakasam				23B. DATE SIGNED 9-7-68	
23C. PHYSICIAN'S NAME (Type) G. MATHIPRAKASAM				23D. ADDRESS Lutheran Hospital 2 Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-68		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert S. Indiana		25C. FUNERAL DIRECTOR Phyllis Twined Lane	
				ADDRESS 1727 N. Towhee St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 68- 9466	
BIRTH NO. 68- 9466		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Jones Ethel		2. DATE AND HOUR OF DEATH 9-14-68 11 45 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Memorial Home 27 N. Carey St		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 802 W. Dand St			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec 1893	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Jones, William			14. MOTHER'S MAIDEN NAME Brown, Victoria		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-3838	17. INFORMANT ADDRESS		
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
420.11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-5 19 68 to 9-14 19 68 , that (I) (we) lost saw the deceased alive on 9-14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John A. ...		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-14-68	
23C. PHYSICIAN'S NAME (Type) Harris JENNALINE		23D. ADDRESS 5519 Kennesaw Home, Balt.			
24A. BURIAL CREMATION REMOVAL (Specify) Buried		24B. DATE 9-18-68		24C. NAME of CEMETERY or CREMATORY MT. Calvary	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968			
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR ADDRESS Henry B. ...			

24 3 = 01 10 11

24 3 = 01 10 11

705 9 121 101

24 3 = 01 10 11

20)

24 3 = 01 10 11

24 3 = 01 10 11

24 3 = 01 10 11

24 3 = 01 10 11

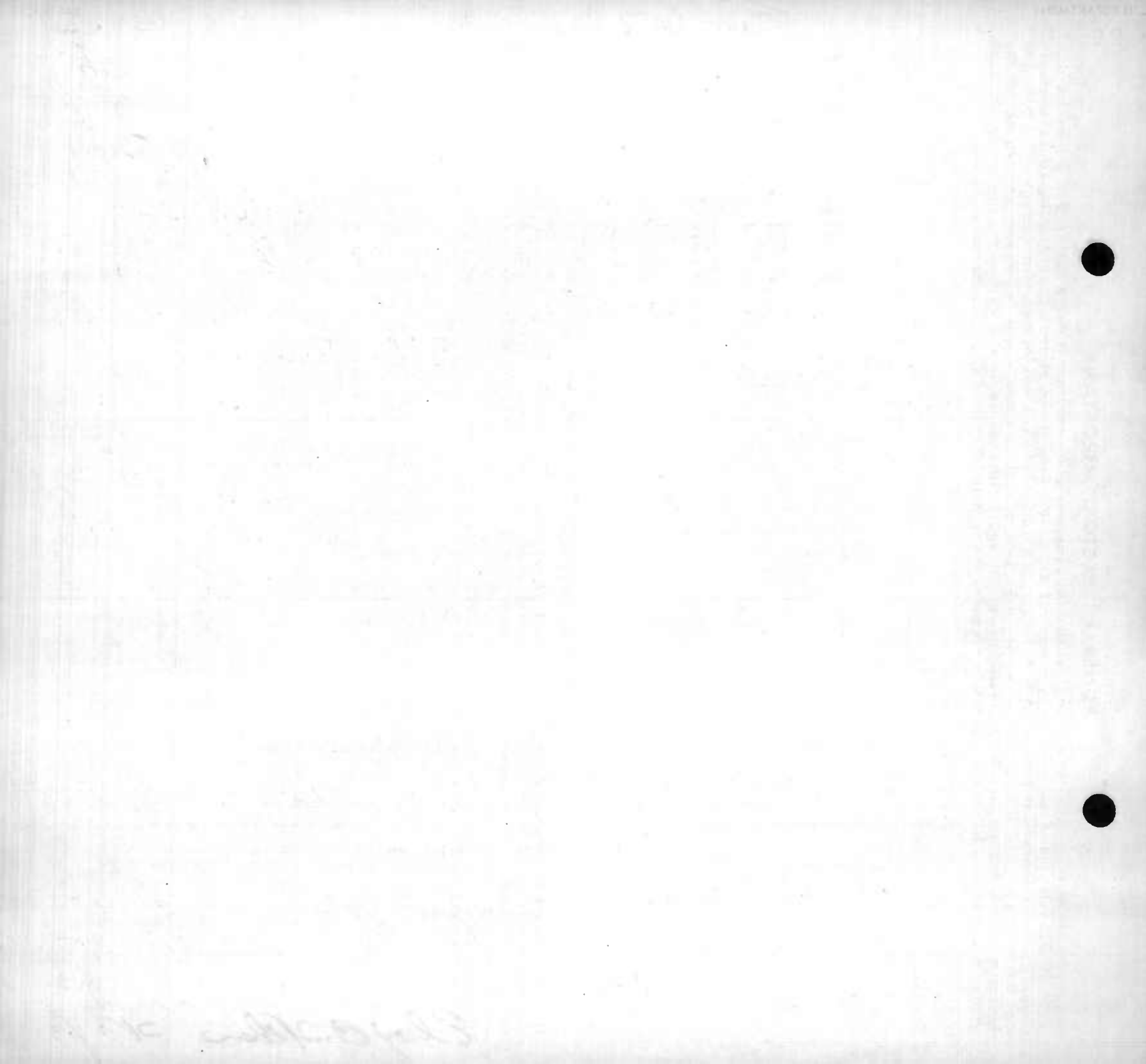
24 3 = 01 10 11

24 3 = 01 10 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68- 9467			
1. NAME OF DECEASED (Type or Print) <i>William PEDEN</i>				2. DATE AND HOUR OF DEATH <i>9/15/68</i> <i>1:35 p. M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>16-01</i>							
FULL NAME OF HOSPITAL OR INSTITUTION <i>39 Provident Hospital Balto, MD</i>				C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <i>1041 Harlem Ave-</i>							
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/7/99</i>		9. AGE (In years lost birthday) <i>69</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Revered Coppe & Brass</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Peden</i>				14. MOTHER'S MAIDEN NAME <i>ELLA Shoemaker</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart - Provident</i>		ADDRESS			
18. <i>412.317-183-X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <i>420.0 II</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Pulmonary Edema</i> (B) <i>ASHD & severe anemia</i> DUE TO, OR AS A CONSEQUENCE OF: <i>G.U. Bleeding due to CP Perforate yro.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>9/9</i> 19 <i>68</i> to <i>9/15</i> 19 <i>68</i> . that (I) (we) lost saw the deceased alive on <i>9/15</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Elisah Saunders</i>				23B. DATE SIGNED <i>9/15/68</i>							
23C. PHYSICIAN'S NAME (Type) <i>ELISAH SAUNDERS</i>				23D. ADDRESS <i>344 Duwall Ave Balto, MD 21216</i>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>9-19-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Arbutus MD</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 17 1968</i>				25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>				25C. FUNERAL DIRECTOR <i>Elroy C. Wilson</i> ADDRESS <i>210 p.</i>			



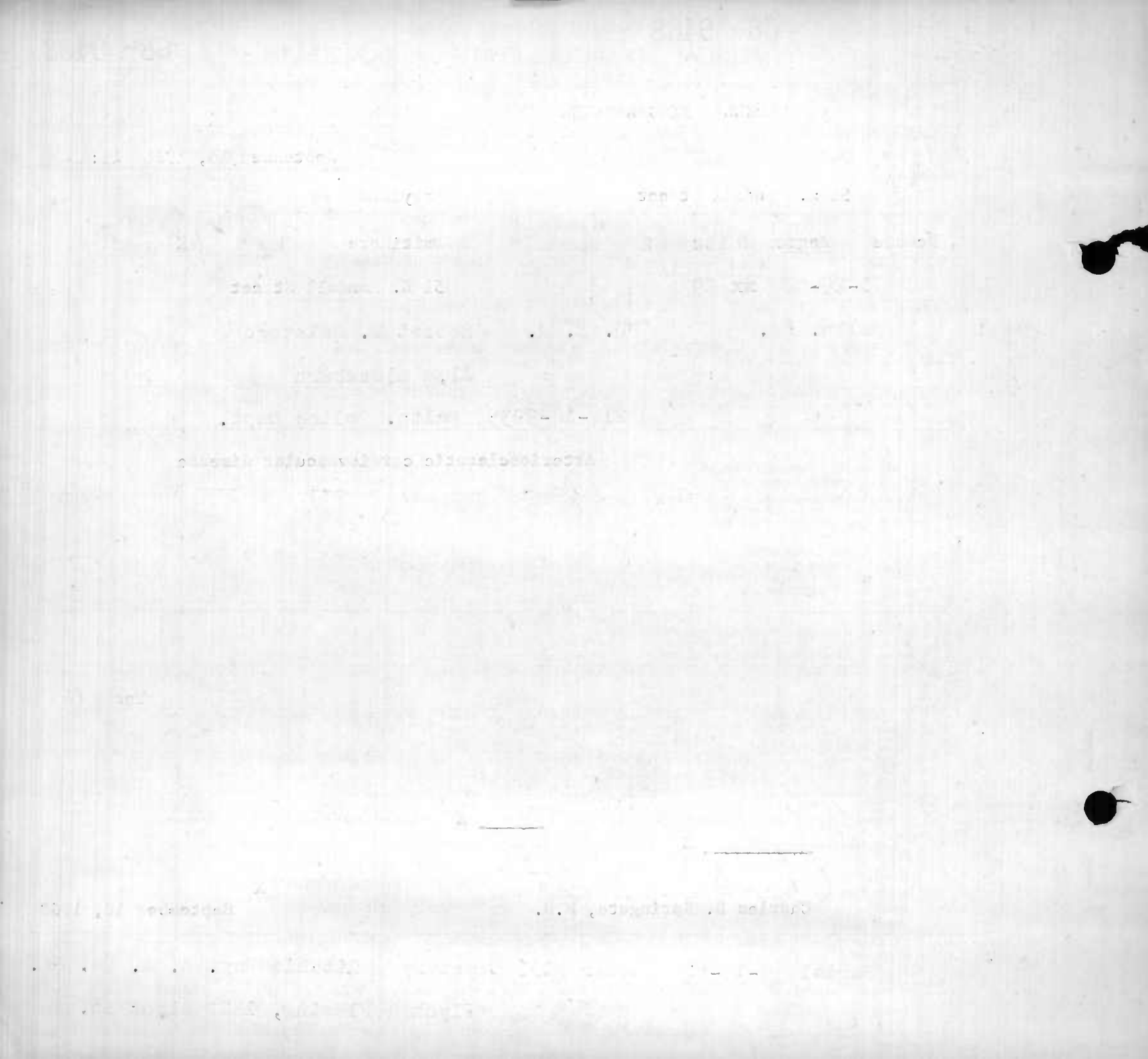
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9468

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ORDELLA KIRCHENBAUER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 ADDRESS OR LOCATION 51 E. Randall Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 16, 1968 11:13 AM	
6. SEX Female	7. RACE Negro White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-25-08		10. AGE (In years lost birthday) 59	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-18-3985	
18. INFORMANT Balto. Police Dept.		ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 16, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-17-68	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Flynn & Fleming,		ADDRESS 1422 Light St.	



1
C-500

68- 9469 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9469

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES A. CAIN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year September 15, 1968		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2123 N. Fulton Avenue		3. DATE PRONOUNCED DEAD Month Day Year September 15, 1968		Hour 10:45 A.M.
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 8-10-1908		10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) Raleigh, N. C.
12. CITIZEN OF U.S.A.		13. FATHER'S NAME UNK.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVERNMENT
15. MOTHER'S MAIDEN NAME Mrs. F. L. K.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)		17. SOCIAL SECURITY NO. 224-05-3167
18. INFORMANT Mrs. Froie Cain		ADDRESS 2123 N. Fulton		19. CAUSE OF DEATH 162.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Bronchogenic carcinoma		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 162.1 II				
20A. DATE OF OPERATION 9-19-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 16, 1968
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-19-68		24C. NAME OF CEMETERY or CREMATORY Pleasant Shade
24D. LOCATION (City, town, or county) (State) Newport News VA.		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Johnson
25C. FUNERAL DIRECTOR MORTON + Dye		ADDRESS 1701 LAURENS		

295

124-02-007 Mrs. Frank Green
124-02-008 W. F. Lee

Bureau - D-19-68 Present 2nd Grade Memphis House V-4
Morton - Det (Det) Bureau

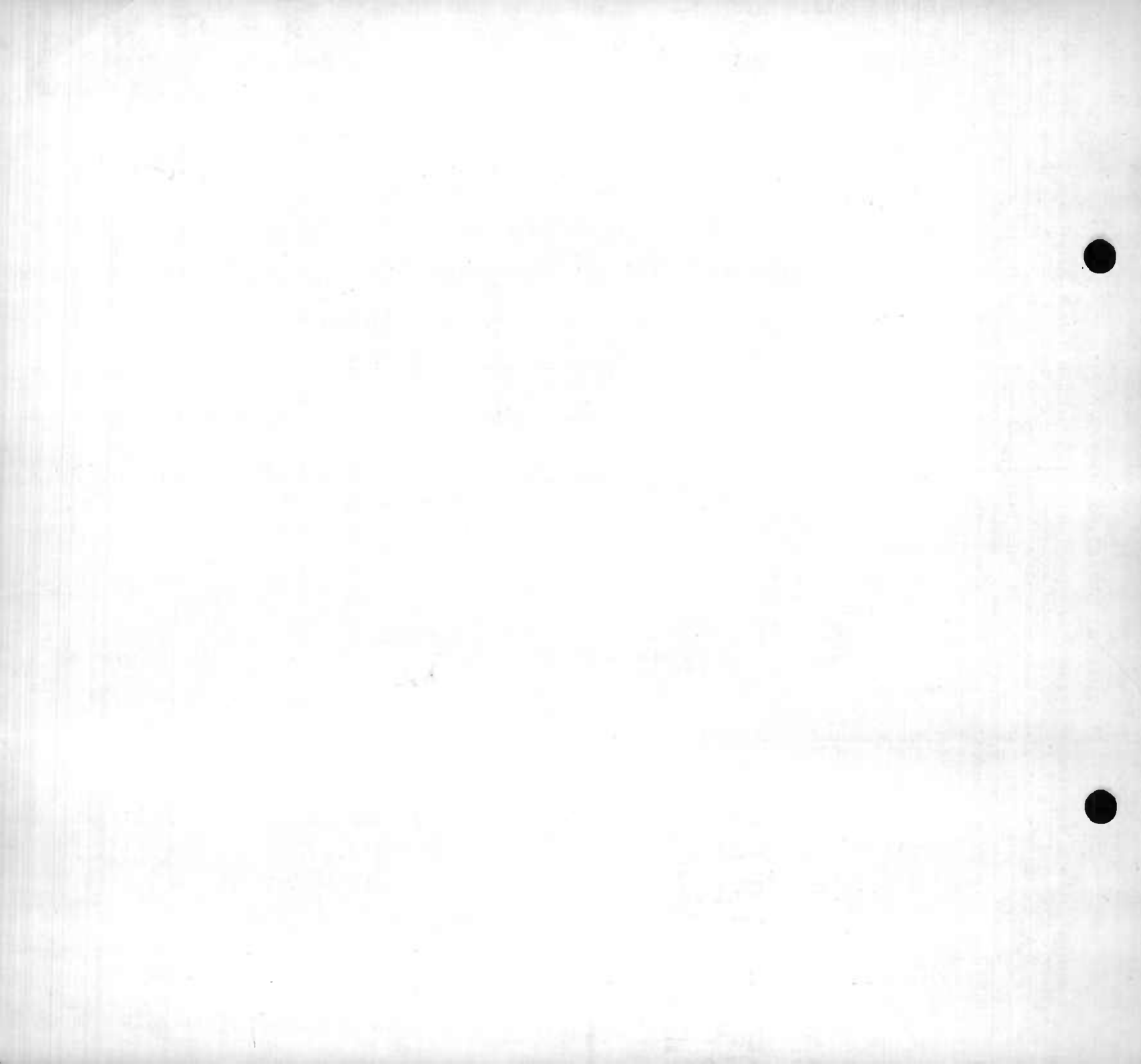
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9470

BIRTH NO.		68- 9470		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Charles Loute			2. DATE AND HOUR OF DEATH 9-12-68 4:47 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 801 EUTAW ST		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 09/11/09	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) "UNIONIST"		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louisiana	
13. FATHER'S NAME Alex Loute			14. MOTHER'S MAIDEN NAME EMMA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 357-14-3524		17. INFORMANT chant	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 173.6 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH 4 Squamous Cell (A) IMMEDIATE CAUSE Metastatic Adeno carcinoma of rectum, anus DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 197.5 II NONE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.		
19A. DATE OF OPERATION 12/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Squamous cell ca anus		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/31 19 68 to 9/12 19 68, that (I) (we) last saw the deceased alive on 9/12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd B. Mandel MD			23B. DATE SIGNED 9/12/68		
23C. PHYSICIAN'S NAME (Type) Lloyd B. Mandel MD			23D. ADDRESS Maryland General Hospital		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/17-68		24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md					
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Frank W. Seitz 814 W 36th St.	



FUNERAL DIRECTOR: IMPORTANT

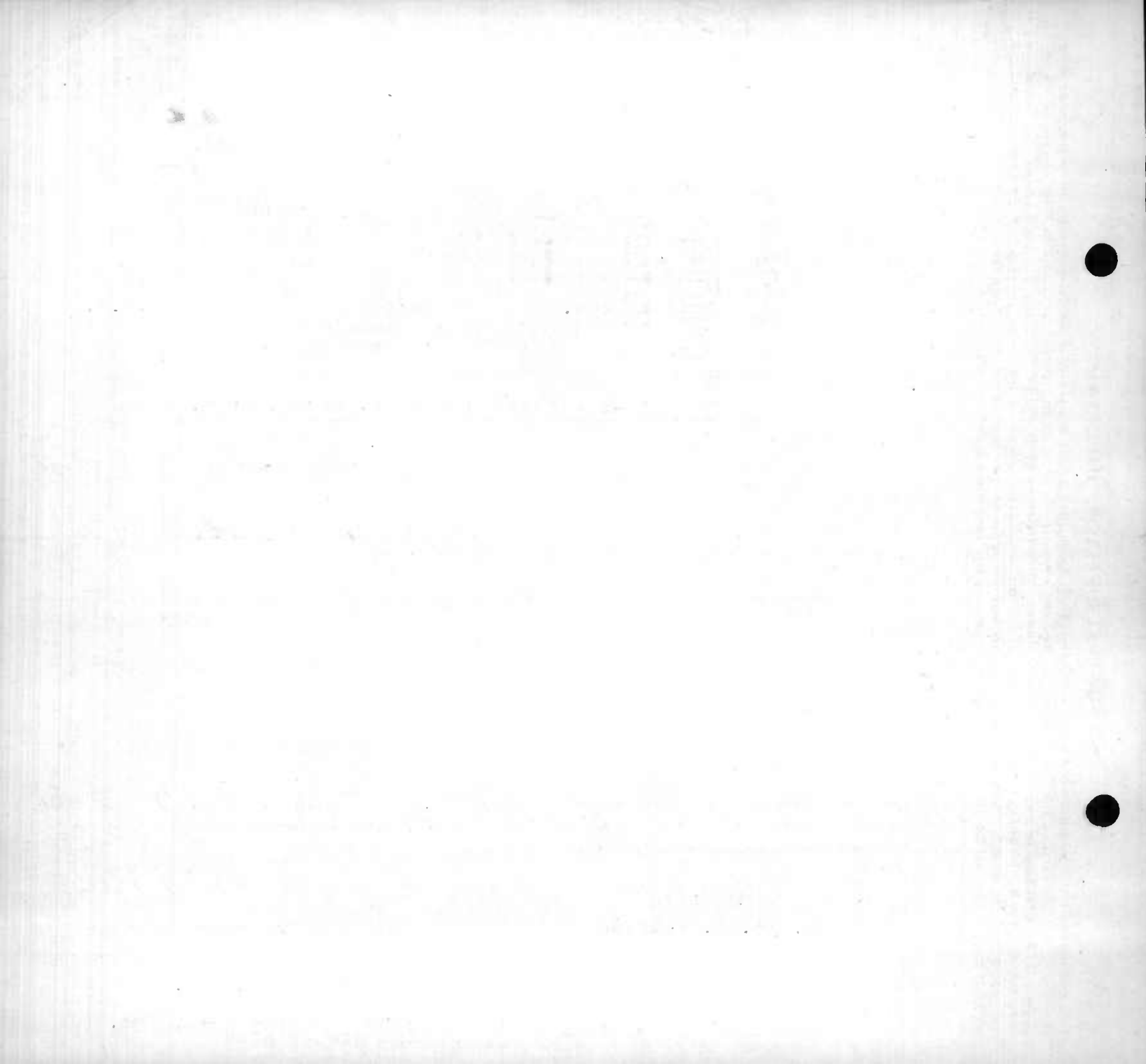
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9471 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9471

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY ANN SADBARAS or SEDBARAS		9/13/68 4:15 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2829 Lake Avenue				A. STATE Md. 21213	
				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2829 Lake Avenue	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/15/02	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Seamstress		Miller Bros.		England	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Joseph Winicarter			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
			220-24-3209A		Frances L. Weber, dght. above
18. 15-3-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cancer Signed</i>			6 months
		(B) <i>Generalized Coronarioris</i>			6 months
		(C)			
15-3-3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
08-14-68		Cancer		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9-7 1968 to 9-13 1968, that (I) (we) last saw the deceased alive on 9-7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William L. Fearing</i>				23B. DATE SIGNED 9-13-68	
23C. PHYSICIAN'S NAME (Type) Dr. Wm. L. Fearing				23D. ADDRESS 3025 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		9/16/68		Holy Redeemer Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 17 1968		Robert E. Fearing		Schimunek Funeral Home, Inc. 3331 Brehms Lane	



68- 9472 CERTIFICATE OF DEATH

REG. NO. 68- 9472

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Gilbert
JAMES SCHAUB

2. DATE AND HOUR OF DEATH

9-15-68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND,

C. CITY OR TOWN
BALTIMORE

E. STREET AND NUMBER

815 N. MILTON AVE.

D. INSIDE CITY LIMITS?

YES ☒ XNO ☐

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☒ XWIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-9-22

9. AGE (In years
last birthday)

46

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sheet Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY

Wallace & Gale

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH SCHAUB

14. MOTHER'S MAIDEN NAME

ANNAX BUSCH

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

217-14-9344

17. INFORMANT

7014 German Hill Road 21222
Marguerite Stenger, sister

ADDRESS

18. 571.01

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Cerebral

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Chronic Alcoholism

(C)

581.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Peptic ulcer disease & GI Bleed.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 9/11 19 68 to 9/15 19 68.

that (1) (we) last saw the deceased alive on 9/15 19 68 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert Jacobs

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒ X

23B. DATE SIGNED

9/15/68

23C. PHYSICIAN'S
NAME (Type)

ROBERT JACOBS, M.D.

DEGREE

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/19/68

24C. NAME OF CEMETERY or CREMATORY

Lorraine Park Cem.

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 17 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

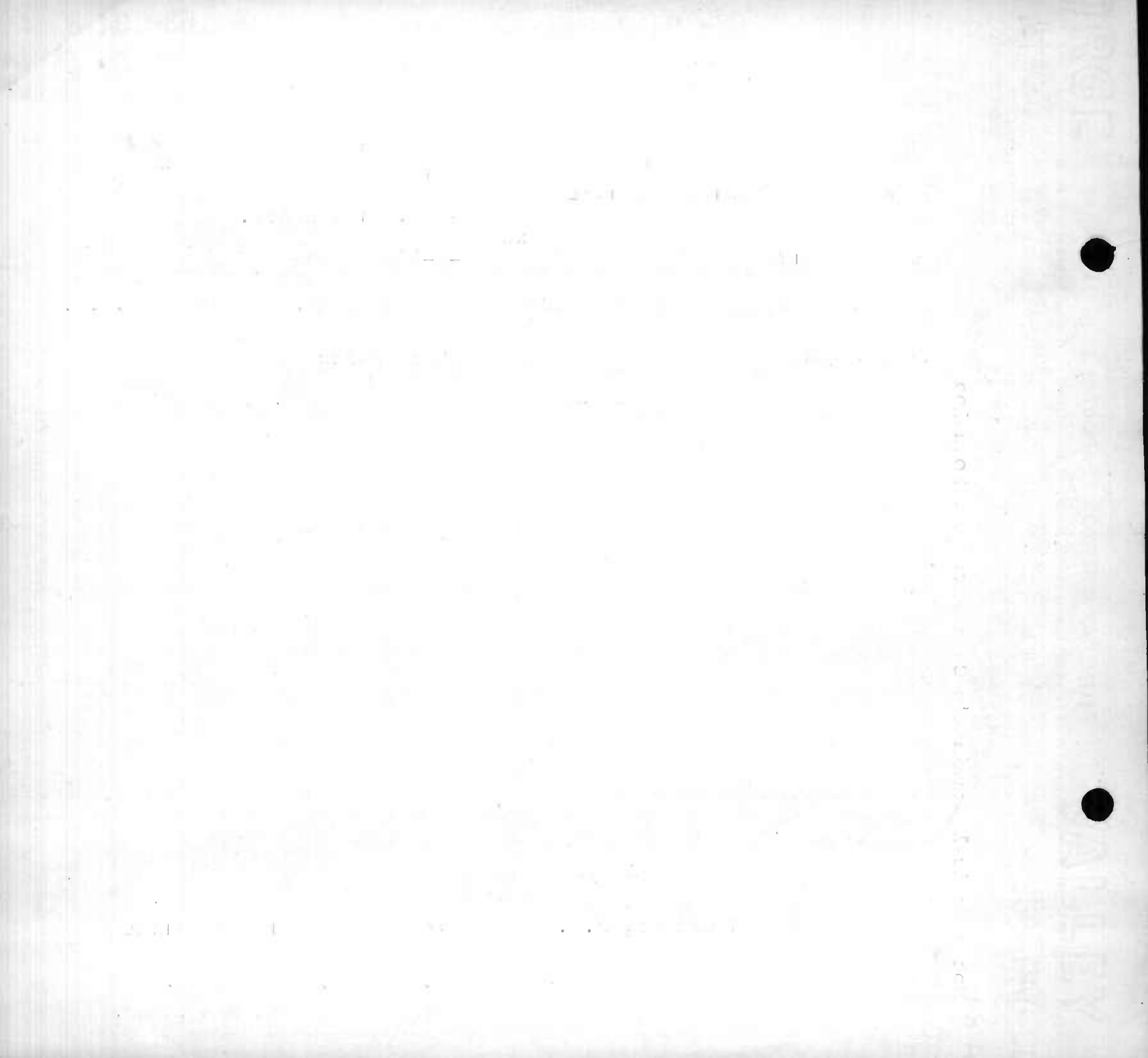
ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Not a Medical Examiner's Case Per: Dr. Kornblum

MEDICAL CERTIFICATION



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-07337				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-9473	
1. NAME OF DECEASED (Type or Print) THERESA MAPLE				2. DATE AND HOUR OF DEATH Sept 13 1968, 2:45 PM 2:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL, BALTIMORE, MD 21201				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN BALTIMORE D. INS. OF CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1529 EDMONDSON AVE.			
5. SEX F		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-14-67	
9. AGE (In years last birthday) 17		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME EDWARD MAPLE			
14. MOTHER'S MAIDEN NAME MARGARET JACKSON				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —			
16. SOCIAL SECURITY NO. —				17. INFORMANT CHART ADDRESS			
18. 7109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Septicemia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septic arthritis & Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) —				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
19. 220X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumothorax, osteomyelitis				MEDICAL CERTIFICATION			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-18-1968 to 9-13-1968, that (I) (we) last saw the deceased alive on 9-13-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE S. Aziz M.D.				23B. DATE SIGNED 9-13-68		23C. PHYSICIAN'S NAME (Type) SHANID AZIZ M.D.	
23D. ADDRESS 38 UNIVERSITY HOSPITAL, BALTIMORE, MD 21201				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/16/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) Balto. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Williams Funeral Home 319 N. Charles St.			



FUNERAL DIRECTOR: IMPORTANT

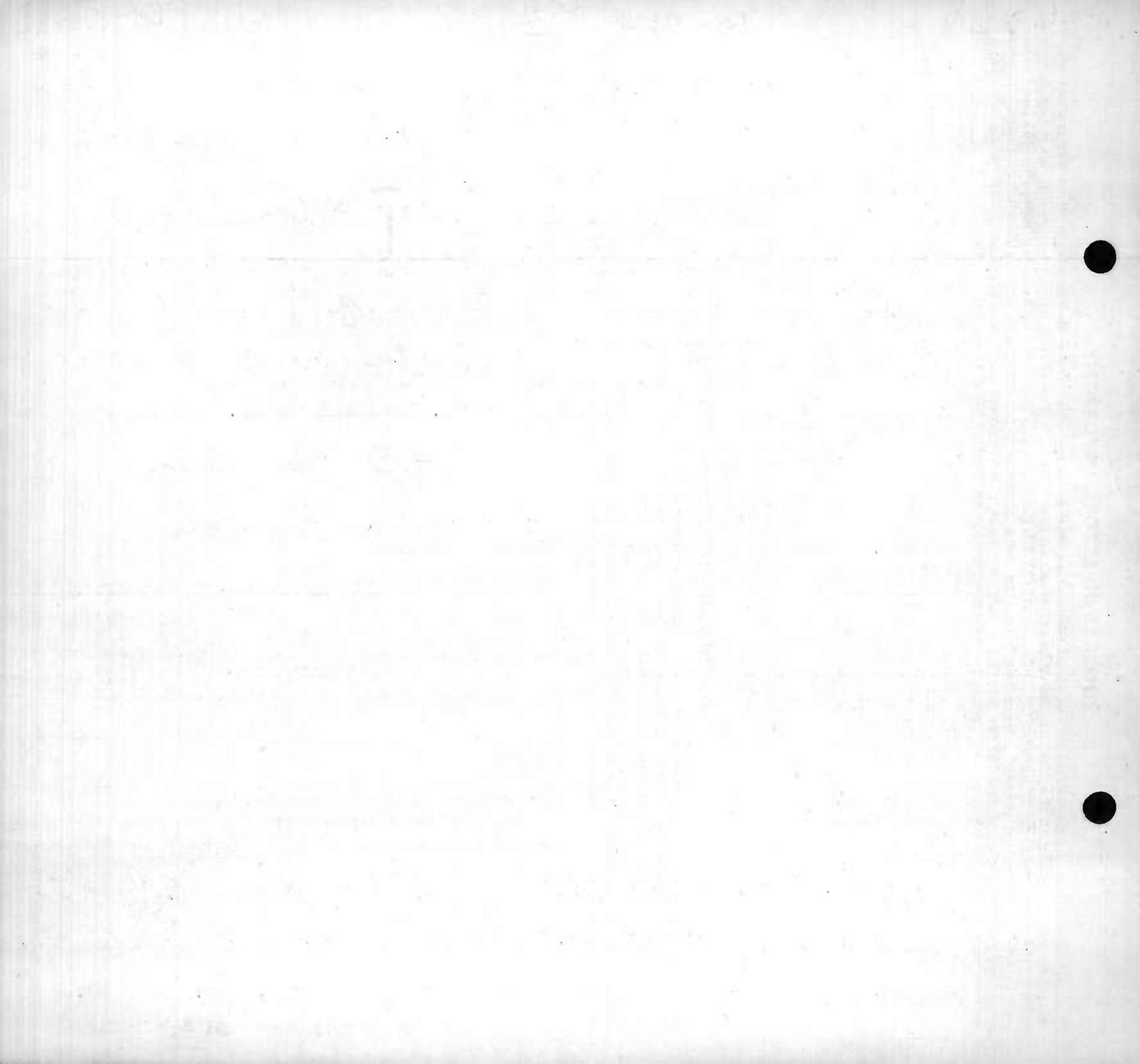
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9474 **CERTIFICATE OF DEATH**

REG. NO.

68- 9474

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Charles Porter</u>		2. DATE AND HOUR OF DEATH <u>9-15-68</u> <u>11:20 a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>53-00</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Montebello State Hospital</u> <u>91</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>separated</u> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		8. DATE OF BIRTH <u>7-13-1898</u>	
13. FATHER'S NAME <u>Nicholas R. Porter</u>		14. MOTHER'S MAIDEN NAME <u>Catherine M. Winkler</u>		9. AGE (In years last birthday) <u>70</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-5622A</u>		11. BIRTHPLACE (State or foreign country) <u>Chase, Maryland</u>	
		17. INFORMANT <u>Perry Hall</u> <u>Lan</u> <u>Mr. Charles Porter Jr. Box 216 Snyder</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S. Heart Disease</u> (B) <u>Post morotic Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.0 II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11:20</u> <u>15 Sept</u> <u>19</u> <u>68</u> to <u>19</u> <u>68</u> , that (I) (we) last saw the deceased alive on <u>11:20</u> <u>15 Sept</u> <u>19</u> <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Carl O. Mattsson M.D.</u>		23B. DATE SIGNED <u>15 Sept 68</u>		23C. PHYSICIAN'S NAME (Type) <u>Carl O. Mattsson M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9-19-1968</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1968</u>		25B. NAME OF REGISTRAR <u>Robert C. Jackson</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair 21236</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Co. Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FIORE, FRANK		9-12-68 11:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN BALTIMORE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-24-85		9. AGE (In years last birthday) 83		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bread Salesman		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-26-9596		17. INFORMANT BCH: 4940 EASTERN AVE. RECORDS: BALTO., MD. 21224	
18. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchial Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 491X II		19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-18 1968 to 9-12 1968, that (I) (we) last saw the deceased alive on 9-12 1968, and that in (my) (apinian death occurred on the date and hour and from the causes stated above. (I) (did) (view the body after death.		23A. SIGNATURE Ronald G Michels MD DEGREE		23B. DATE SIGNED 9-13-68	
23C. PHYSICIAN'S NAME (Type) Ronald G Michels DEGREE		23D. ADDRESS 4940 EASTERN AVE. BALTO., MD. Baltimore City Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/16/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cem	
24D. LOCATION (City, town, or county) Balto.		24E. DATE REC'D BY HEALTH DEPT. SEP 17 1968		24F. NAME OF REGISTRAR Robert E. Fashina	
24G. FUNERAL DIRECTOR Joseph N. Zappino		24H. ADDRESS 263 S. Conkling			

General Assembly

yes

more

more

more

more

no

4-15

4-15

4-15

4-15

Renold C. Michael MD

Renold C. Michael

Baltimore City Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9476 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 9476

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Catherine Wilson

2. DATE AND HOUR OF DEATH

11/15/68

1:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital
48

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Baltimore

53-00

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2701 Wildberger Ave

5. SEX

Fe

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

05-10-92

9. AGE (In years last birthday)

76

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hsw. f.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Jones

14. MOTHER'S MAIDEN NAME

Annie Hatzel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-28-3911A

17. INFORMANT

Son

ADDRESS

Walter D. Wilson

Same

18.

4124 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Congestive Heart Failure

(B)

Arteriosclerotic Cardiovascularis

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Congestive At Lower Extremity

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/11/68 to 9/15/68, that (I) (we) lost saw the deceased alive on 9/14/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. L. S. Brown

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9-15-68

23C. PHYSICIAN'S NAME (Type)

M. L. S. Brown

23D. ADDRESS

Maryland Gen'l Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-17-1968

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

Baltimore, Co.

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

SEP 17 1968

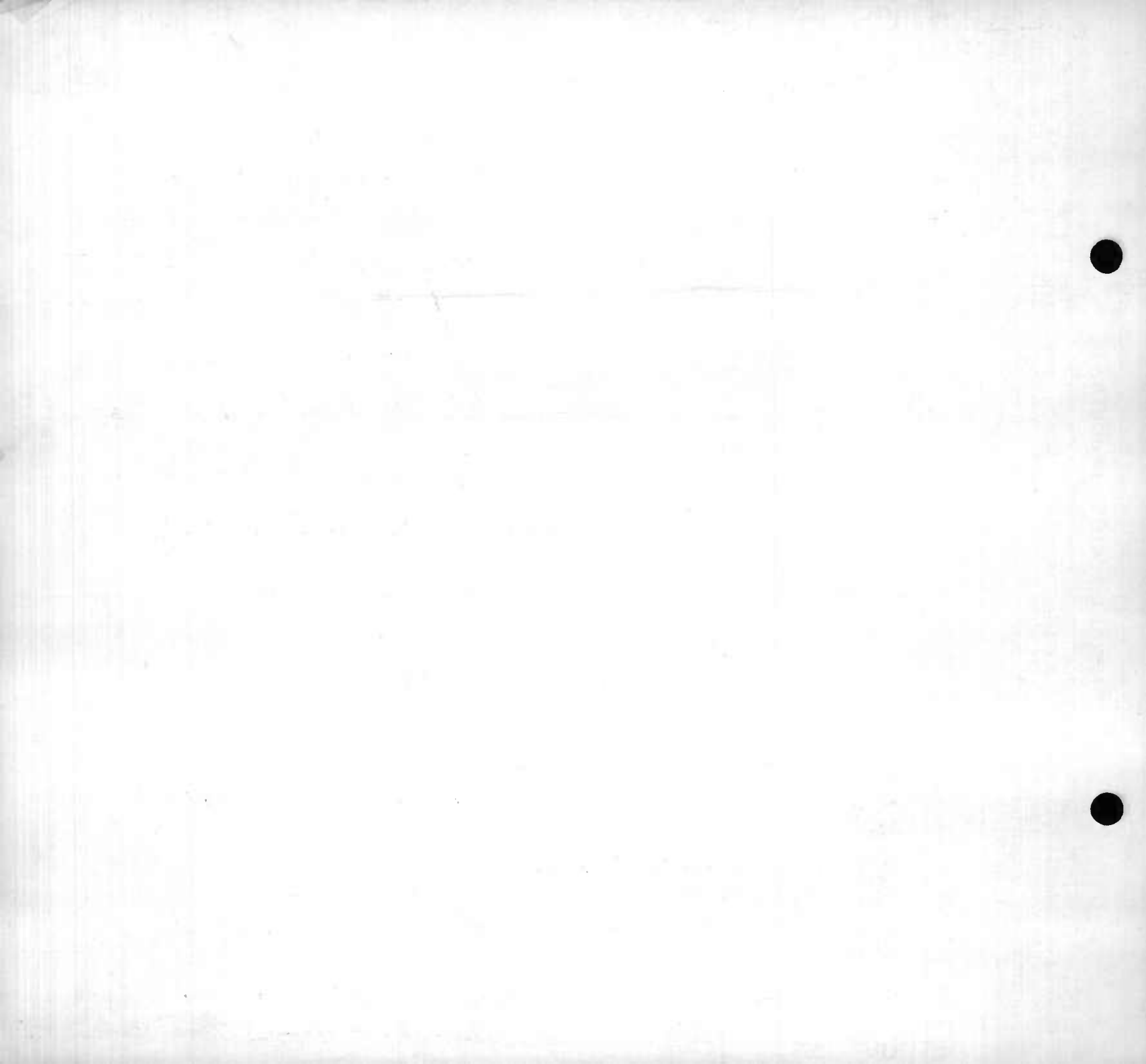
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Lessahn F. Home 7401 Belair Rd.

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9477

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOROTHY SIPPO		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 14, 1968 3:24 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1309 Eastern Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour September 14, 1968 3:45 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH I-14-1919		D. INSIDE CITY LIMITS? 26-05 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 50?		E. STREET AND NUMBER 5309 Eastern Avenue	
11. BIRTHPLACE (State or foreign country) Canton Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lawson Latham		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
15. MOTHER'S MAIDEN NAME Margaret Fitzpatrick		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 359-03-7007		18. INFORMANT Hazel Baxter	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of Liver		CAUSE OF DEATH Cirrhosis of Liver	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. DATE OF OPERATION		23. AUTOPSY? (Yes or No) yes (Partial)	
24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. TIME OF INJURY (APPROX.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Ronald N. Kornblum M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-17-1968	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. J. [Signature]	
25C. FUNERAL DIRECTOR WALTER DABROWSKI		ADDRESS 1005 DUNDALK AVENUE	

WALLACE BOON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9478
BIRTH NO. 68- 9478		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type of Print) Elmer L. Hughes		2. DATE AND HOUR OF DEATH 9/11/68 11 40 PM		
3. PLACE IN BALTIMORE, MARYLAND , WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 6908 RIVER DRIVE ROAD				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-92	9. AGE (In years lost birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME WILLIAM HUGHES		14. MOTHER'S MAIDEN NAME ALICE FOWLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT (Wife) Edgemere, Md. 21219 Mrs. Ida E. Hughes, 6908 Riverdrive Rd.
18. 344.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: L Lung Mass, ? Carcinoma No aneurysm (B) paraplegia + DUE TO, OR AS A CONSEQUENCE OF: (C) lung pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 35-2X II				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 23 19 68 to Sept 11 19 68 , that (I) (we) last saw the deceased alive on Sept 11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE David L. Jackson		23B. DATE SIGNED 9/11/68		
23C. PHYSICIAN'S NAME (Type) DAVID L. JACKSON		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery
24D. LOCATION Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.

10. The following are the names of the people who have been elected to the office of Mayor of the City of New York:

(1) Regard (2) E = 4 (3) Regard

Dr. David T. Jackson

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 9479

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES MAXWELL HARPER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 10 68 Hour 9:10 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) City Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour September 10 1968 9:10 p.m.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Dundalk	
9. DATE OF BIRTH Nov. 30, 1920		10. AGE (In years lost birthday) 47	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sgt. 1/C Retired		14B. KIND OF BUSINESS OR INDUSTRY U. S. Army	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 184-16-0961	
15. MOTHER'S MAIDEN NAME Mary Myers		18. INFORMANT (Wife) Mrs. Cornelia M. Harper, 1707 Dundalk Ave.	
19. CAUSE OF DEATH 571.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of the liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 381.0 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21. AUTOPSY? (Yes or No) YES	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Sept. 11, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	

MA

100-100000

100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9480
<div style="display: flex; justify-content: space-between;"> 68-9480 CERTIFICATE OF DEATH 68-9480 </div>				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) Mary E. Luparello			2. DATE AND HOUR OF DEATH September 15th 1968 10:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital			A. STATE Maryland	
			B. COUNTY Baltimore	
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 2827 Wells Rd.	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/10/03	9. AGE (In years lost birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Walter Humes			14. MOTHER'S MAIDEN NAME Jennierova M. Kendall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 228-18-5287	17. INFORMANT (Husband) Mr. Sam J. Luparello, 2827 Wells Rd.	
18. 427.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Failure			CAUSE OF DEATH Congestive heart failure	
19. 434.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 31st 19 68 to September 15th 19 68 , that (I) (we) last saw the deceased alive on September 15th 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE E. M. De los Santos Jr. M.D.				23B. DATE SIGNED 9/15/68
23C. PHYSICIAN'S NAME (Type) E. M. DE LOS SANTOS JR. M.D.				23D. ADDRESS UGH Maryland General Hospital
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/18/68	24C. NAME of CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Bel Air, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.

1997

Old friend and B.M.B.
C. M. B. M. B. M. B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9481 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 9481

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PARRISH, DAYLON KENT		2. DATE AND HOUR OF DEATH 9-13-68 12:20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, 53-00 B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL ; WILKENS & CATON - BALTIMORE, MD. 21229		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 1701 KIRKLAND ST. BALTO. MD. 21222	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-49	9. AGE (In years lost birthday) 18	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME DAYLON C. PARRISH		14. MOTHER'S MAIDEN NAME EUNICE PROCTOR		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT WILKENS & CATON SAINT XXX AGNES RECORDS	
18. 191X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Brain Tumor Malignant 3rd Ventricle Astrocytoma Gr III.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19 193.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION Sep. 12 '68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-3- 1968 to 9-13 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9-13 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE Tse Shiung Wu <i>Resident</i>				23B. DATE SIGNED 9-13-68	
23C. PHYSICIAN'S NAME (Type) Tse Shiung Wu		23D. ADDRESS ST. AGNES HOSP. WILKENS & CATON			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/17/68		24C. NAME OF CEMETERY or CREMATORY Floral Gardens	
24D. LOCATION Guliford Co. High Point, N.C.		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR John J. Duda			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9482

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 9482

BIRTH NO.

1. NAME OF DECEASED **Frank L. Maurer Sr.**
(Type or Print) **FRANK L. MAURER**

2. DATE AND HOUR OF DEATH

9-15-68

11:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4 NORTH CHARLES GEN. HOSPITAL
North Charles General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md. BALTIMORE

53-00

C. CITY OR TOWN **Back River** D. INSIDE CITY LIMITS?

BALTIMORE Co.

YES ☐

NO ☒

E. STREET AND NUMBER

8054 Lansdale Rd.

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10-20-1899

9. AGE (In years last birthday)

68

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED- Guard, American Brewing Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Co. MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN MAURER

14. MOTHER'S MAIDEN NAME

Anna WATKINS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL SECURITY NO.

215-10-2337A

17. INFORMANT (Wife)

Mrs. Marie Maurer,

Balto. Md. 21224

8054 Lansdale Rd.

18. **153.8 I**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

TERMINAL Ca, Colon

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

153.8 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **9-15** 19 **68** to **9-15** 19 **68**, that (I) (we) last saw the deceased alive on **9-15** 19 **68** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Emmanuel M. Maniago, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9-15-68

23C. PHYSICIAN'S NAME (Type)

EMMANUEL M. MANIAGO

M.D.

DEGREE

23D. ADDRESS

NORTH CHARLES GEN. HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/19/68

24C. NAME OF CEMETERY or CREMATORY

Meadowridge Memorial Park

24D. LOCATION

(City, town, or county)

Dorsey, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 17 1968

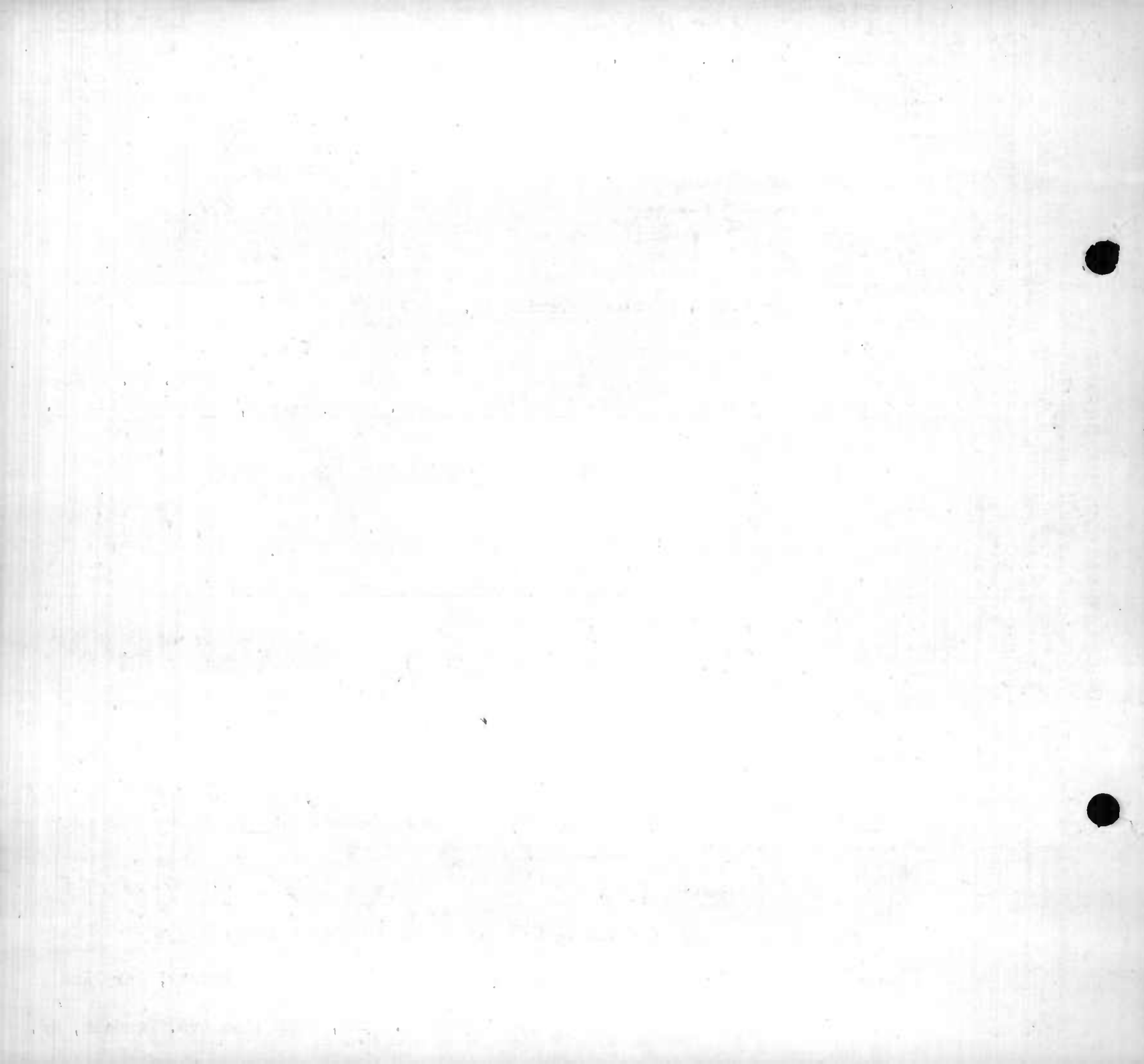
25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9483

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Isidor Feldman

2. DATE AND HOUR OF DEATH

15 Sept '68 6:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Balto

E. STREET AND NUMBER

6314 Greenspring Ave.

5. SEX

♂

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

15 March 1885 83

9. AGE (In years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-36-7078

17. INFORMANT

ADDRESS

Mrs. Jean Moffet 6314 Greenspring Ave.

18. 159X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused the death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cancer of pancreas or stomach

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 years

MEDICAL CERTIFICATION

19. 15-9X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

White At Work ☐

Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/29 19 68 to 9/15 19 68, that (I) (we) last saw the deceased alive on 9/15 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert Brull M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9/15/68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Sept 16, 1968

24C. NAME OF CEMETERY or CREMATORY

Abraham S. Holom

24D. LOCATION

Balto

(City, town, or county)

(State)

25A. DATE REC'D. BY HEALTH DEPT.

SEP 17 1968

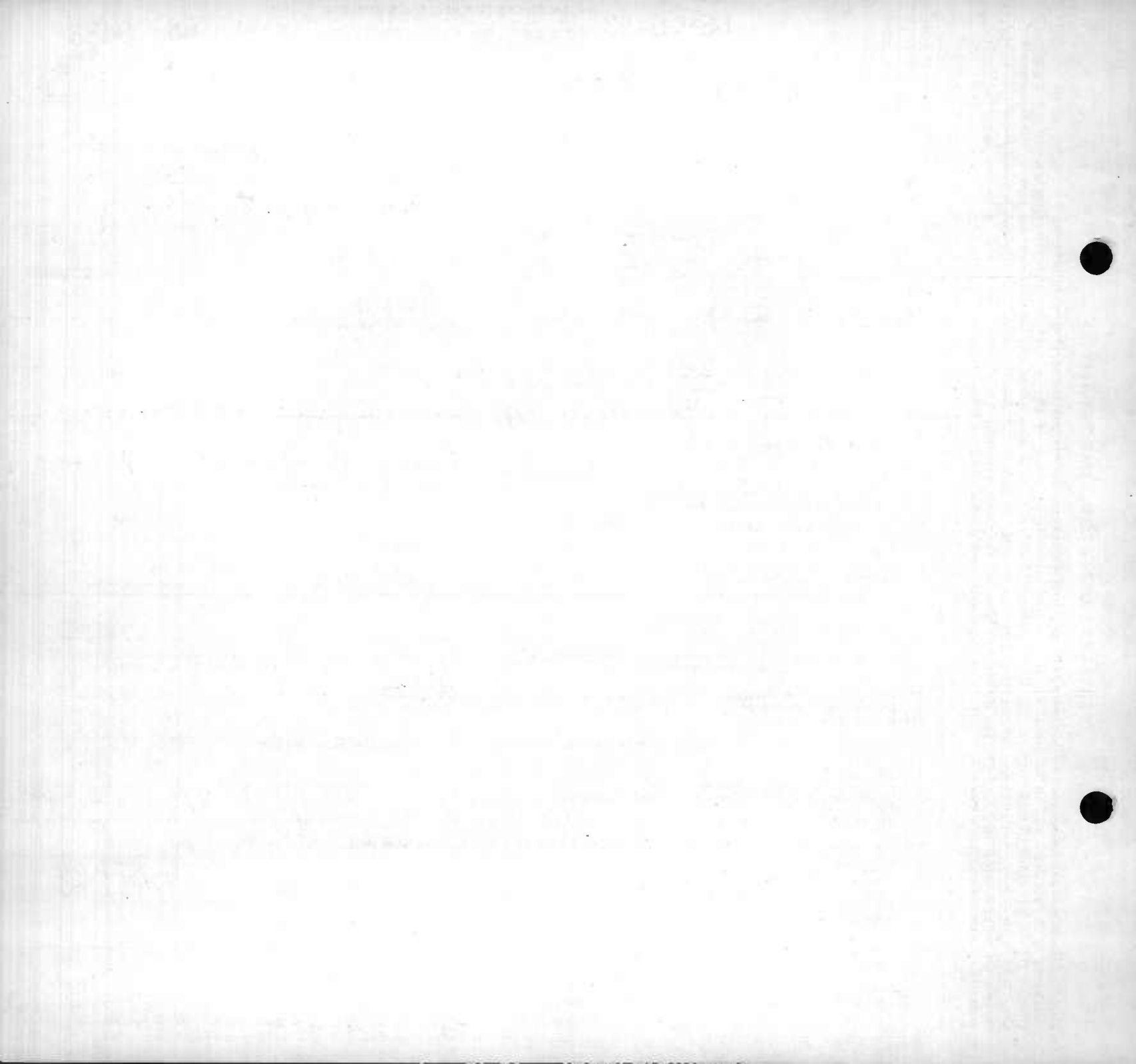
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Sylvan S. Lewis & Son, Inc. 9610 Reisterstown Rd

ADDRESS



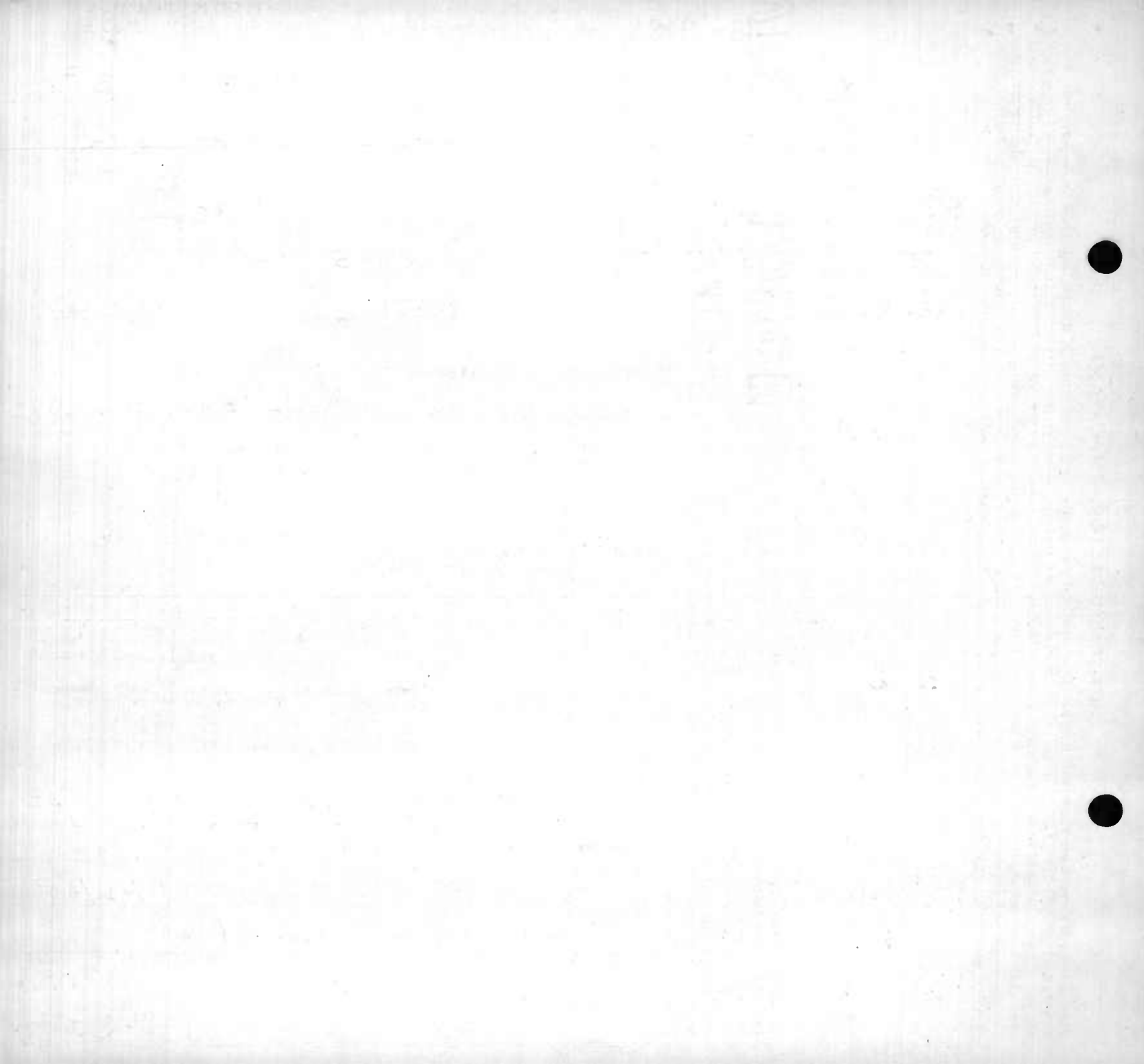
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9484 CERTIFICATE OF DEATH

REG. NO. **68- 9484**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Milton Sattler		2. DATE AND HOUR OF DEATH 9/11/1968 3:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY Balto	
FULL NAME OF HOSPITAL OR INSTITUTION Behreder Nursing Home				C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL ADDRESS OR LOCATION 90				E. STREET AND NUMBER 3526 Greenway Ave	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27, 1895	9. AGE (in years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-4076		17. INFORMANT Mrs Norma Jones	
18. 23091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cardio-Respiratory Failure		CAUSE OF DEATH (A) IMMEDIATE CAUSE Constrictive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: Cardiomyopathy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction, old		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 3 1963 to Sept 11 1968 , that (I) (we) last saw the deceased alive on Sept 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Willard Appleford MD				23B. DATE SIGNED 9/12/68	
23C. PHYSICIAN'S NAME (Type) Willard Appleford MD				23D. ADDRESS 6615 Reisterstown Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/68		24C. NAME OF CEMETERY or CREMATORY Forland	
24D. LOCATION Balto		24E. (City, town, or county)		24F. (State) md	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc	
25D. ADDRESS 9610 Reisterstown Rd					



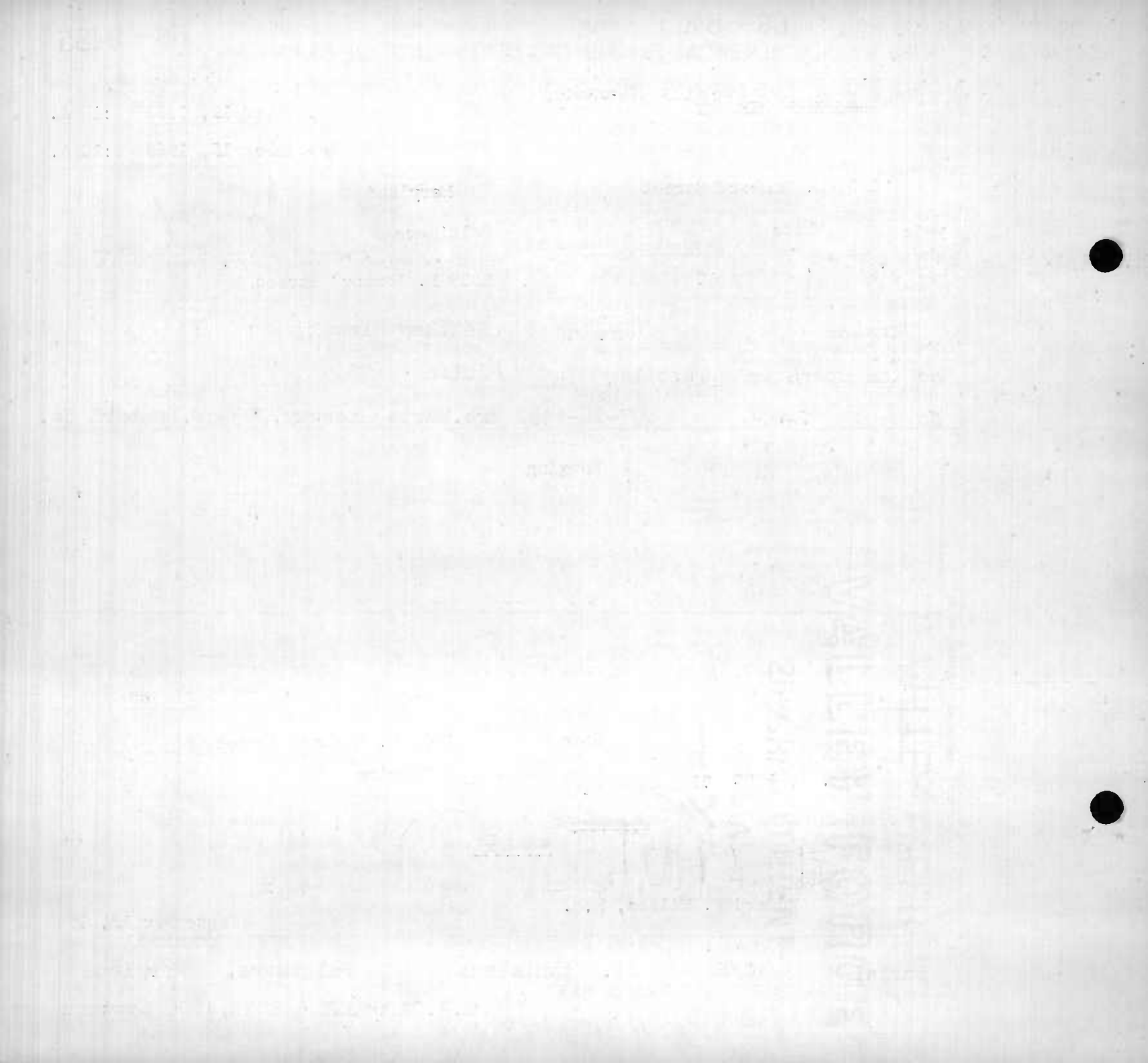
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9485

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) WOSSILY WASILY HIEWSKY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 15, 1968 8:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2039 E. Lombard Street		3. DATE PRONOUNCED DEAD Month Day Year September 15, 1968 8:10 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 201	
9. DATE OF BIRTH 7/26/19		10. AGE (In years last birthday) 49 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? Ukraine	
13. FATHER'S NAME Matthew Hiewsky		14. MOTHER'S MAIDEN NAME Julia ??	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		14B. KIND OF BUSINESS OR INDUSTRY Textile	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 097-28-1452	
18. INFORMANT Mrs. Maria Hiewsky, 2039 E. Lombard St.		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E 9331X Hanging		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 974X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 6		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2039 E. Lombard Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Sept. ? 1968 ??	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Hanging	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED September 15, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/68	
24C. NAME of CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1968		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 Eastern Ave		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9486 CERTIFICATE OF DEATH

REG. NO. 68- 9486

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John Conrad</i>		2. DATE AND HOUR OF DEATH <i>9-15-68</i> <i>10 35 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Anne Arundel</i> <i>52-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Glen Burnie</i>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>28 April 1906</i> <i>62</i>		9. AGE (In years lost birthday) <i>62</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Warehouseman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Marie C. Conrad, same as 4</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>694X I</i>		CAUSE OF DEATH <i>Mamie Pulmonary Embolus Momentary</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Generalized Coagulopathy positive</i>		<i>several years</i>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Staphylococcal Sepsis</i>		(C) <i>Pneumonia vulgaris</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>704.1 II</i>					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 17</i> 19 <i>68</i> to <i>Sept 15</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Sept 15</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Werner Beck, M.D.</i>				23B. DATE SIGNED <i>9-16-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Werner Beck, M.D.</i>				23D. ADDRESS <i>Mercy Hospital, Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>20 Sept. 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Memorial Park</i>	
24D. LOCATION <i>Glen Burnie, AA Co., Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>SEP 17 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
24G. FUNERAL DIRECTOR <i>Kirkley Funeral Home, Glen Burnie, Md.</i>		24H. ADDRESS		24I. DATE	

100

Baltimore, Maryland

Bellevue

Westborough

Unknown

Unknown

John C. Corbett, born on 4

in

John Corbett, AA Co., MA

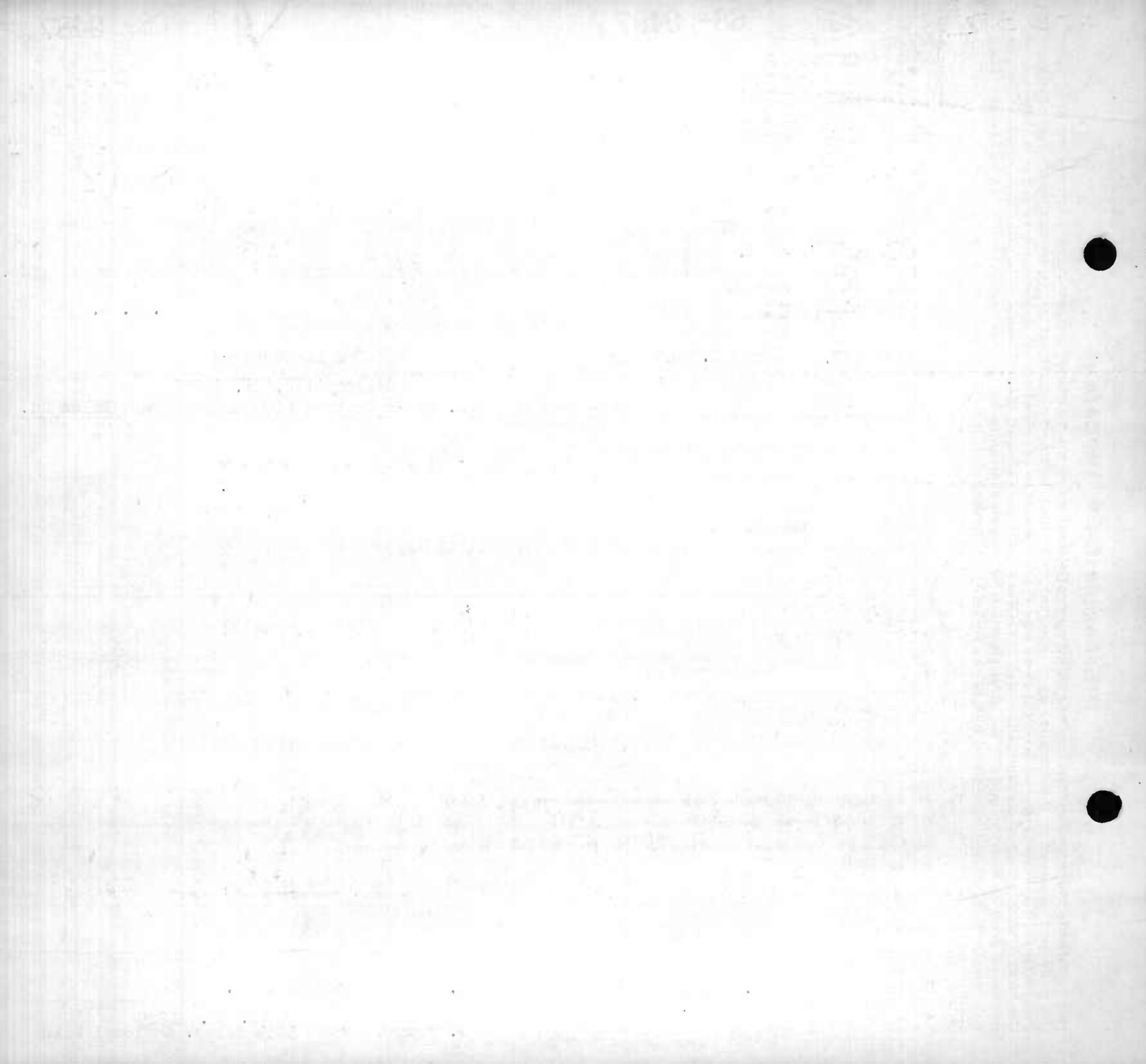
John Corbett, AA Co., MA

John Corbett, AA Co., MA

John Corbett, AA Co., MA

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) George Pantazis (Pantazis)		2. DATE AND HOUR OF DEATH 15 Sept 1968 2:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 5300		
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital 42			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1223 Newfield Rd 21207
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/15	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner		10B. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME James G. Pantazis		
14. MOTHER'S MAIDEN NAME Despina Orfanos			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-18-9250			17. INFORMANT Catonsville, Md. 21229 Mrs. Peter Coutros 6200 Gilston Park DEPT Rd.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Abdominal Cancer primary to unknown		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 199.2 II Bilateral Pneumonia					
19A. DATE OF OPERATION 199.2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 4 19 68 to Sept 15 19 68 , that (I) (we) last saw the deceased alive on Sept 15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Brull M.D.			23B. DATE SIGNED 15 Sep '68		23C. PHYSICIAN'S NAME (Type) Robert Brull
23D. ADDRESS Balto. Md. 21229			23E. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 18, 1968		24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cem.	
24D. LOCATION Woodlawn, Md.		24E. ADDRESS Balto. Md. 21229			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike	



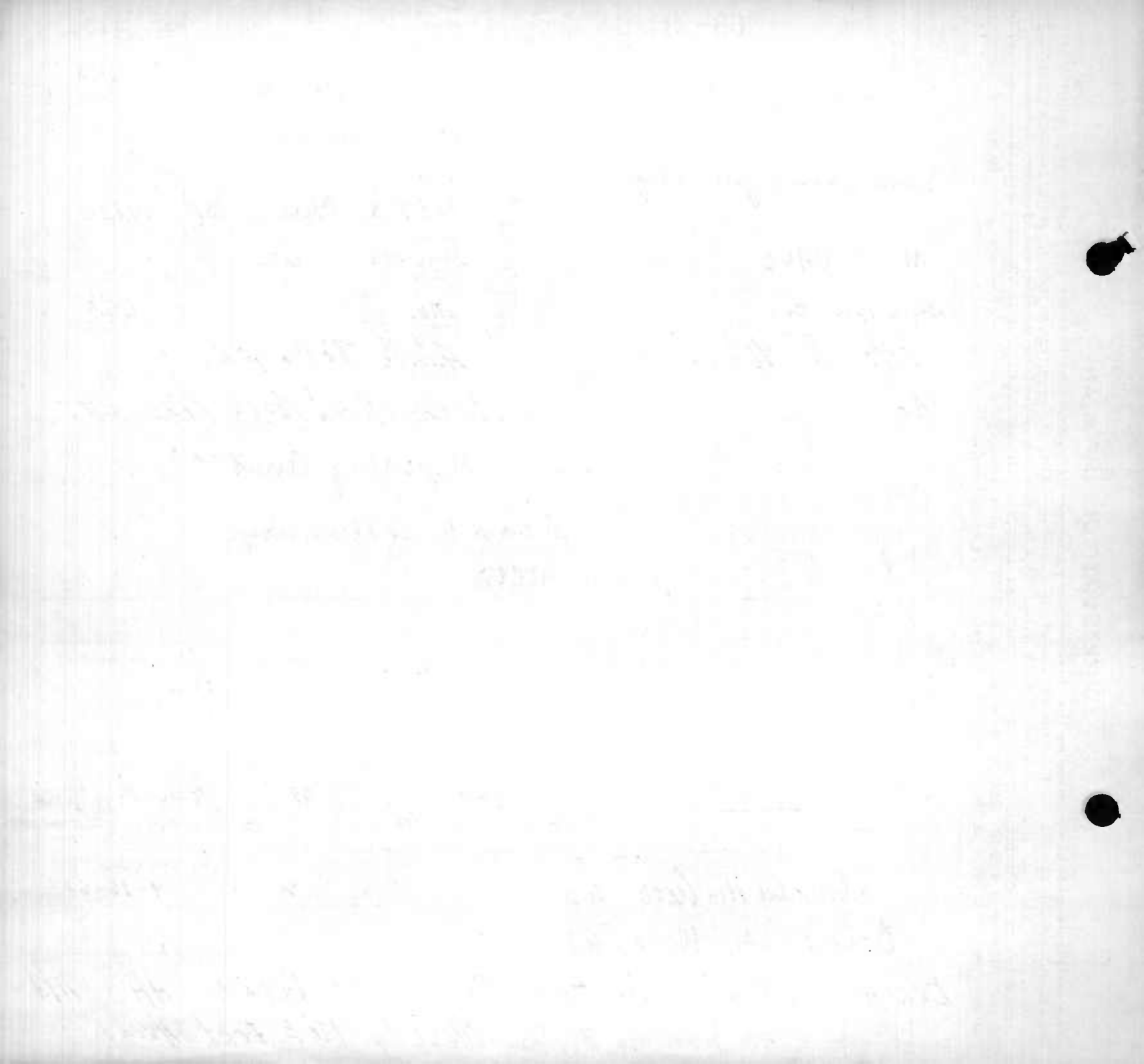
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9488 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9488

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>WARD, Eli</i>		2. DATE AND HOUR OF DEATH <i>9-16-68 435 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i>		C. CITY OR TOWN <i>BALTO.</i> D. INSIDE OR OUT LIMITS? <i>23</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Balto. Gen. Hosp.</i> <i>43</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>1837 S CHARLES ST 21230</i>	
5. SEX <i>M</i>	6. RACE <i>CAUC</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-16-06</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BALTO TEL CO.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <i>Mo.</i>	
13. FATHER'S NAME <i>Eli J WARD</i>		14. MOTHER'S MAIDEN NAME <i>Addie Dellinger</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Marie Ward 1837 S. Char. St.</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory Arrest</i> (B) <i>Subarachnoid Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-7</i> 19 <i>68</i> to <i>9-16</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>9-16</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Donald M. Wood, M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-16-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DONALD M. WOOD, M.D.</i>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>9/18/68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Glen Burnie AA MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 18 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>McCully 130 E. Fort Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9489 CERTIFICATE OF DEATH

REG. NO. 68- 9489

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Orem, John Stanley</u>		2. DATE AND HOUR OF DEATH <u>September 16th 1968 12:55 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>53-00</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 Saint Agnes Hospital Caton & Wilkens Aves. 21229</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Fed. Reserv. Bank</u>		8. DATE OF BIRTH <u>2/1/02</u>	
13. FATHER'S NAME <u>Charles Orem</u>		14. MOTHER'S MAIDEN NAME <u>Florence Marsh</u>		9. AGE (In years last birthday) <u>66</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-30-7522</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>	
17. INFORMANT <u>Mrs. Caroline H. Orem-</u>		ADDRESS <u>4907 Wilkins Ave. -21228</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PERUTE MYOCARDIAL INFARCTION</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINS</u>	
19A. DATE OF OPERATION <u>0 ---</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 66</u> to <u>Sept. 16, 19 68</u> , that (I) (we) lost saw the deceased alive on <u>August 1, 19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John H. Shaw</u>		23B. DATE SIGNED <u>Sept. 16, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>John H. Shaw</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/19/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 18 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Sterling Funeral Estate</u>	
				ADDRESS <u>736 Edmondson Ave. Catonville, MD 21228</u>	

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/1/01 BY 60322 UCBAW

FUNERAL DIRECTOR: IMPORTANT

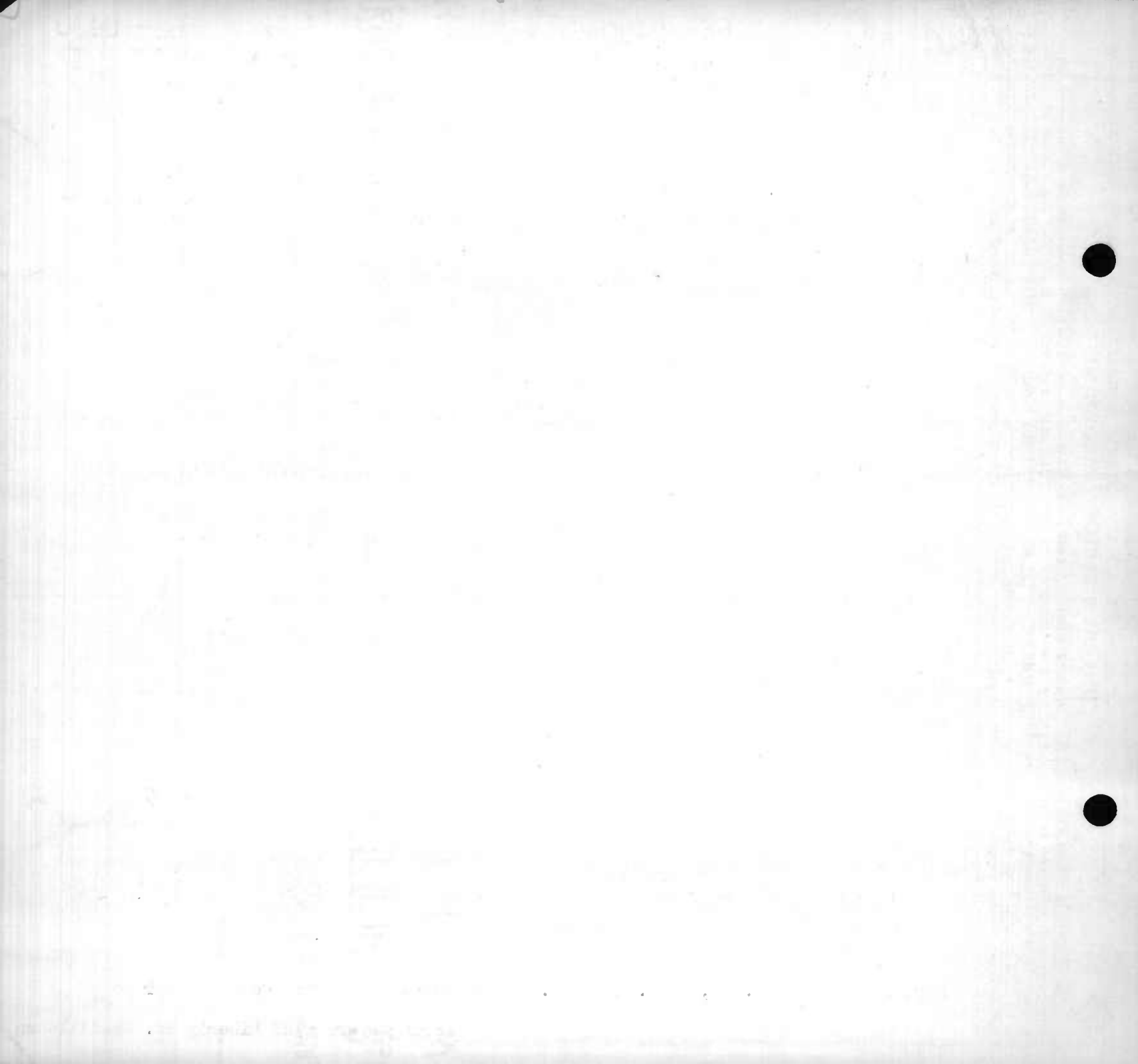
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 9490 CERTIFICATE OF DEATH

REG. NO.

68- 9490

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Morris Wheatley		2. DATE AND HOUR OF DEATH 9-16-68, 2:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 21207		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen. Hosp. 827 Linden Ave. BALTO., Md. 21201		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Certified Public Accountant		10B. KIND OF BUSINESS OR INDUSTRY		B. DATE OF BIRTH 2-8-06	
11. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years last birthday) 62		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Wheatley		14. MOTHER'S MAIDEN NAME Mary Lucas		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 242-05-5334		17. INFORMANT Freida Wheatley		ADDRESS Same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 163.0 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-pulmonary Arrest (B) Malignancy of (L) Pleura (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White A1 <input type="checkbox"/> Not White A1 Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-22 19 68 to 9-16 19 68 , that (I) (we) last saw the deceased alive on 9-16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Delia C. Gomez, M.D.		23B. DATE SIGNED 9-16-68		23C. PHYSICIAN'S NAME (Type) Delia C. Gomez, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 19, 68		24C. NAME of CEMETERY or CREMATORY Mt. View Cem. Howard County	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Loring Byers	
24D. LOCATION (City, town, or county) Howard County Maryland		25D. ADDRESS 8728 Liberty Rd. Randallston			



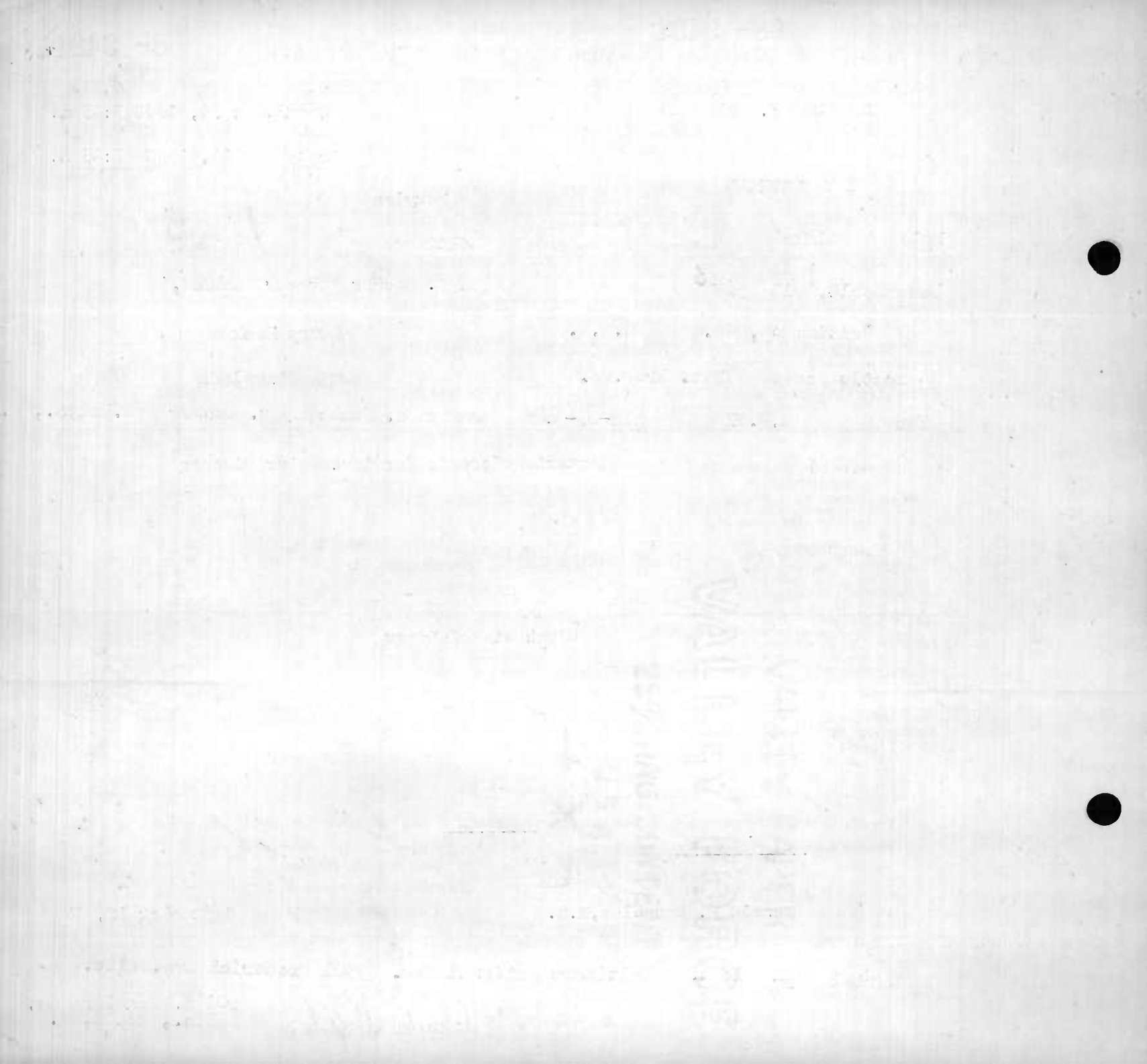
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 9491

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES P. MACK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 14, 1968 7:45 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 14, 1968 7:45 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH December 10, 1911 56		10. AGE (In years last birthday) 56 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottle House		14B. KIND OF BUSINESS OR INDUSTRY Nat. Brew. Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		17. SOCIAL SECURITY NO. 212-07-3020	
18. INFORMANT Evelyn E. Mack		ADDRESS 709 S. Decker Street • # 21224,	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II Cirrhosis of Liver		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED September 15, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9- 18 -68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave. Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Charles S. Feiler		ADDRESS 901 S. Conkling St. Balto., 21224, Md.	

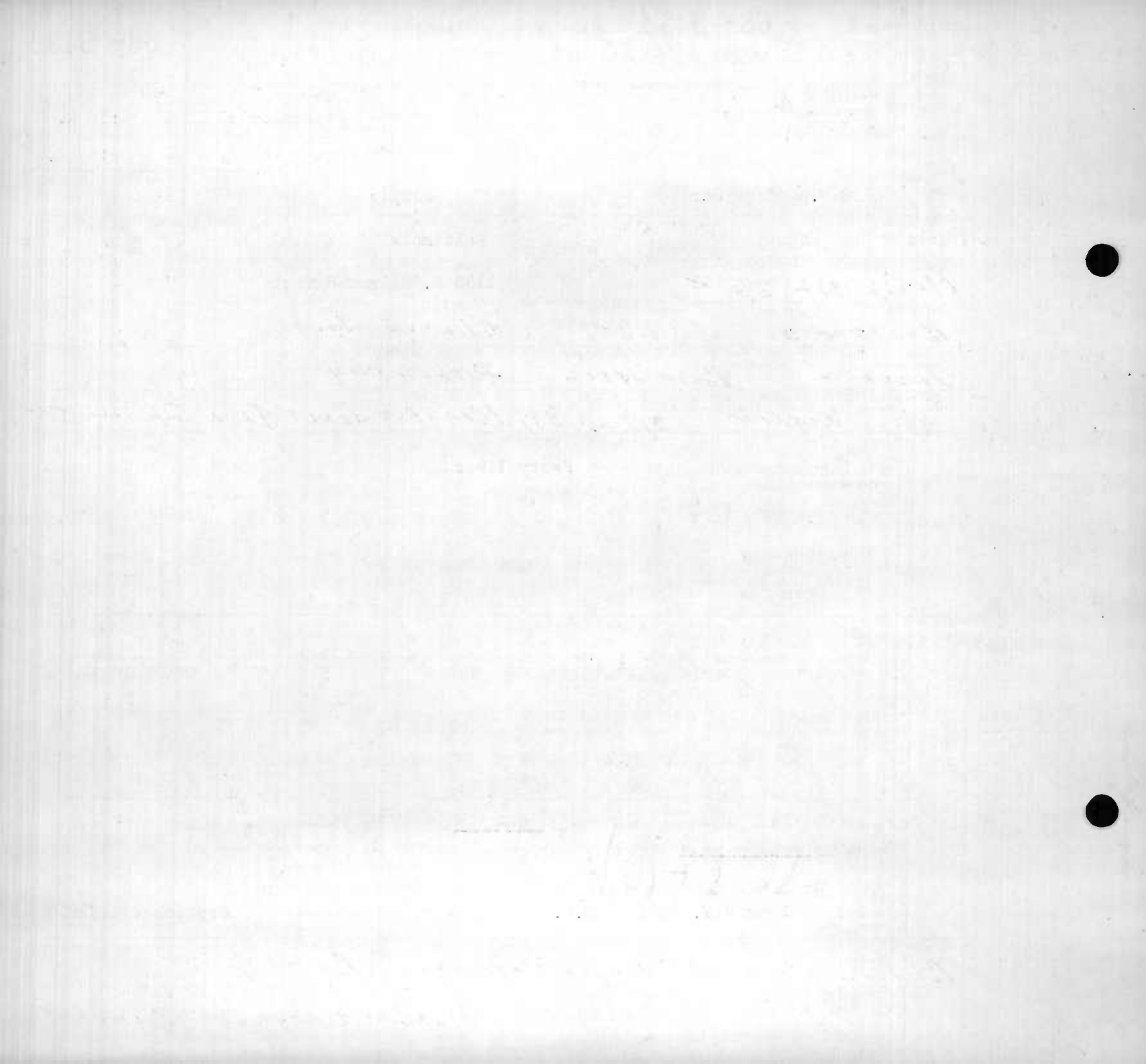


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLINTON JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 17, 1968 6:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1130 N. Gilmore Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 17, 1968 6:50 A. M.	
6. SEX Male		7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH MAY 22-1932		10. AGE (In years lost birthday) 36	11. BIRTHPLACE (State or foreign country) BALTO MD
12. CITIZEN OF USA		13. FATHER'S NAME CLINTON JONES	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		15. MOTHER'S MAIDEN NAME ESTHER MAY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		17. SOCIAL SECURITY NO. 318-28-1397	
18. INFORMANT MARY ANN JONES		ADDRESS 920 N Gilmore St	
19. CAUSE OF DEATH 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 571.0 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 8		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 17, 1968 ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-20-68	
24C. NAME OF CEMETERY or CREMATORY BALTO NATIONAL		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Manhattan [unclear]		ADDRESS 685 N Gilmore St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 9493 CERTIFICATE OF DEATH

REG. NO. 68- 9493

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SARAH W. SMILEY

2. DATE AND HOUR OF DEATH

9/16/68 10:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BON SECOURS HOSPITAL
4 FAYETTE J PULASKI ST.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MARYLAND
JOPPA

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

1006 FERN DRIVE

5. SEX

Female

6. RACE

Cau

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

6/1/79

9. AGE (In years lost by age)

89

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LUKE BIEZEL

14. MOTHER'S MAIDEN NAME

WOLF Susan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-54-5363

17. INFORMANT

Mrs Emma V. Christine 106 Fern Drive Joppa, Md. 21085

18. 427.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Cardio-Respiratory failure 9-16-68

(B) DUE TO, OR AS A CONSEQUENCE OF:

Congestive heart failure 7-27-68

(C) 2 of 3rd stage gastro-intestinal bleeding 9-12-68

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

434.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 27 19 68 to September 16 19 68, that (I) (we) last saw the deceased alive on September 16, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. XAP

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

BON SECOURS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-19-1968

24C. NAME OF CEMETERY or CREMATORY

Grace Reformed Cemetery

24D. LOCATION

Tanneytown Carrol Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 18 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair Road

1000 E. 10th Ave

11/17/81

MARKLAND

WOLF

LUKE BIEZEL

Carla Bergquist
Wright and Paul
1/1/82

Jeffrey P. 11/18/81

BOH RECORDS HOPKINS

8/16/81

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 9494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 9494

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CATHERINE A. TOULAS		2. DATE AND HOUR OF DEATH 9-16-68 7:50 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY B		
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home + Hosp 100 N. BROADWAY BALT. MD 21231			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY -		8. DATE OF BIRTH 10-10-95	
13. FATHER'S NAME JACOB SWIST		14. MOTHER'S MAIDEN NAME ANNA ?		9. AGE (In years last birthday) 72 yr	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 215037683		12. CITIZEN OF WHAT COUNTRY? United States	
17. INFORMANT Mr. George Toulas			ADDRESS 918 E. Belvedere Ave		
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTEROSCLEROTIC HEART DISEASE, Pulmonary edema, ventricular & auricular arrhythmia					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ✓		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9. 12 19 68 to 9. 16 19 68 , that (I) (we) lost saw the deceased alive on 9. 16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MESBAH UD-DOWLA				23B. DATE SIGNED 9/16/68	
23C. PHYSICIAN'S NAME (Type) MESBAH UD-DOWLA MD				23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/20/68		24C. NAME of CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (Specify) XOXOXOX			
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR John E. Janney		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE.	

WESTERN CO. DUCK AND CHICKEN HATCH AND HATCHES

✓
12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

RECEIVED FROM WEST BEAC
RECEIVED FROM WEST BEAC

RECEIVED FROM WEST BEAC

RECEIVED FROM WEST BEAC

JACK SWIFT

RECEIVED FROM WEST BEAC

RECEIVED FROM WEST BEAC

RECEIVED FROM WEST BEAC

RECEIVED FROM WEST BEAC

RECEIVED FROM WEST BEAC

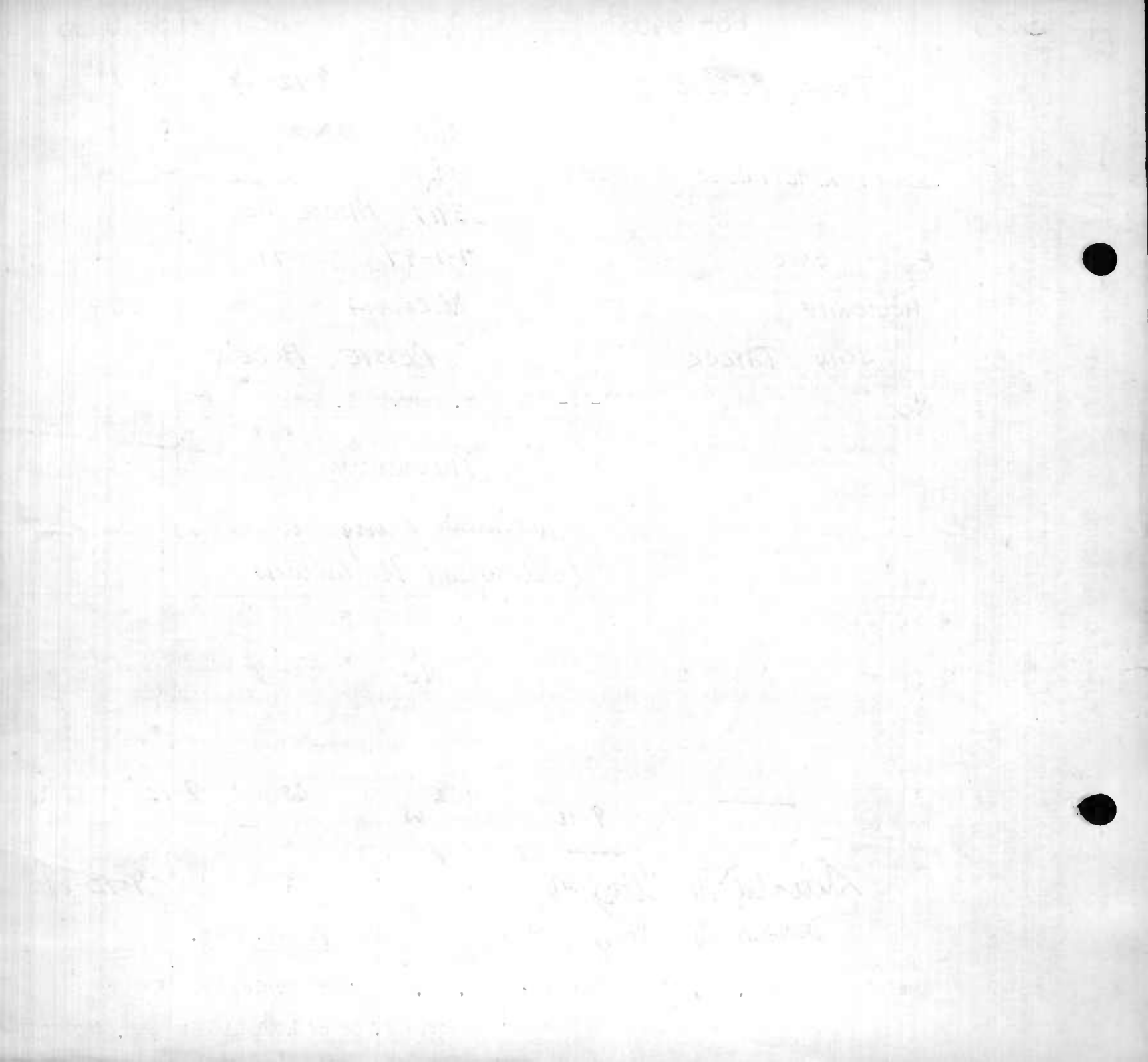
RECEIVED FROM WEST BEAC

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 9495 CERTIFICATE OF DEATH

REG. NO. 68- 9495

BIRTH NO.		1. NAME OF DECEASED (Type or Print) TATE, BESSIE I.		2. DATE AND HOUR OF DEATH 9-12-68 7⁵⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.		
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL 43			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3917 PASCAL AVE.		
5. SEX F	6. RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-97	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) MIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN TAYLOR			14. MOTHER'S MAIDEN NAME BESSIE BODEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 231-16-3607	17. INFORMANT Mr. Renney L. Tate ADDRESS Same		
18. 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonitis (B) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma Lung (C) Widespread Metastasis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-2 19 68 to 9-12 19 68 , that (I) (we) last saw the deceased alive on 9-12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald M. Wood MD			23B. DATE SIGNED 9-12-68		23C. PHYSICIAN'S NAME (Type) DONALD M. WOOD MD
23D. ADDRESS South Baltimore Gen. Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Sept. 16, 1968	24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Pk.		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968	25B. NAME OF REGISTRAR R. B. E. Johnson	25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. (221225)	



1
U-536

68- 9496 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9496

BIRTH NO.

AMBLER

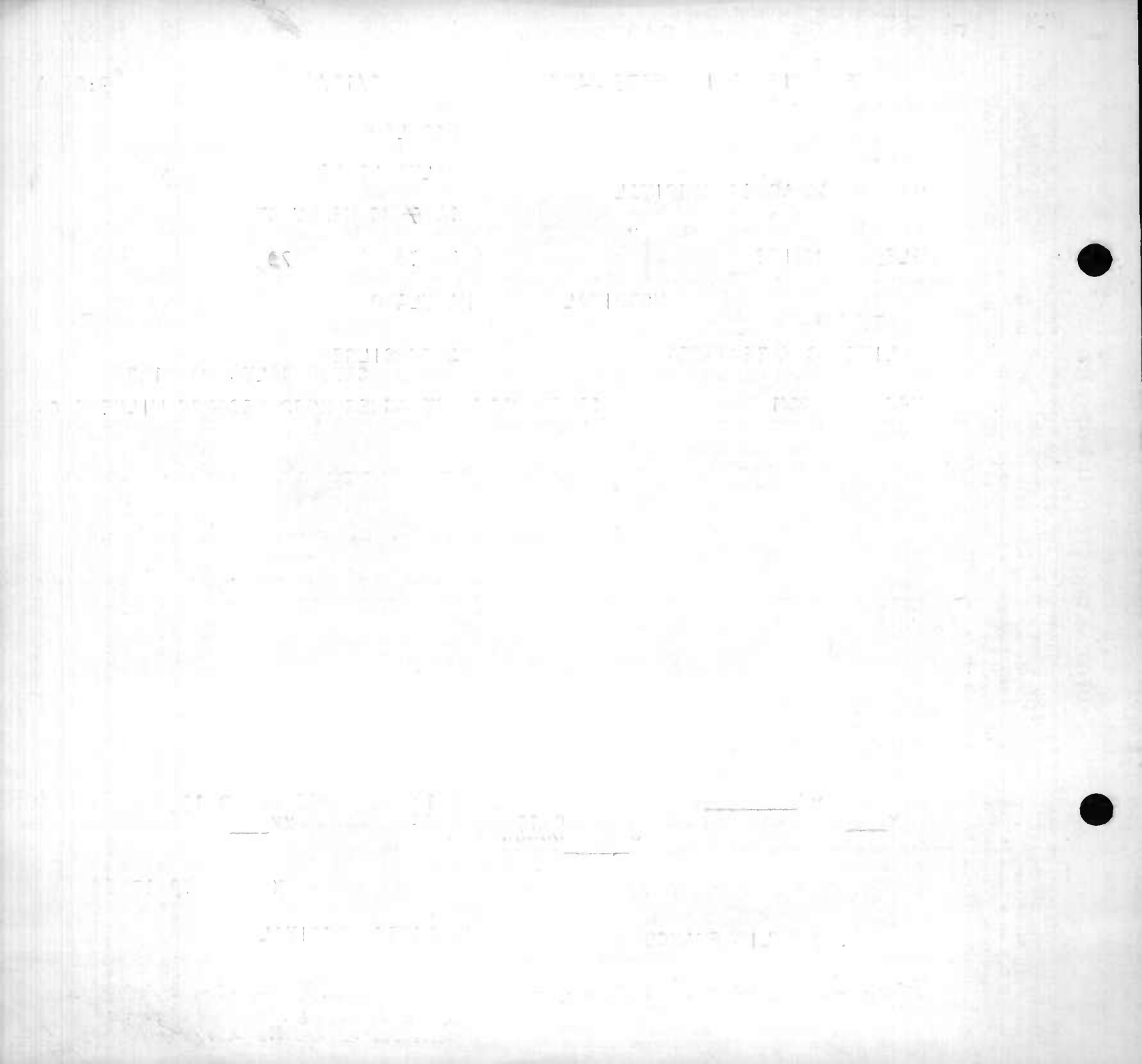
1. NAME OF DECEASED (Type or Print) WALTER A UNDERWOOD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 16, 1968		Hour 1:05 P. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year September 16, 1968		Hour 1:05 P. M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE				
6. SEX Male	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore Lochearn
9. DATE OF BIRTH June 4, 1915		10. AGE (In years lost birthday) 53	E. STREET AND NUMBER 6708 Laurel Drive	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME WALTER Underwood	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Inspector		15. MOTHER'S MAIDEN NAME Gertrude Murphy		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES World War II		17. SOCIAL SECURITY NO. 216-07-9867	18. INFORMANT Phyllis Underwood	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 - 5		
20A. DATE OF OPERATION 4-22-67		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)		DATE SIGNED September 17, 1968		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-20-68	24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home
				ADDRESS 2101 Frederick Ave

Deceased Marriage Record dated July 22, 1941
From Bel Air, Md. 3-10-69 M:VH.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 9497
1A-251		68- 9497		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANCIS MARION FAZENBAKER		2. DATE AND HOUR OF DEATH 9/17/68 9:20 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTO 21223 E. STREET AND NUMBER 1404 MC HENRY ST D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 26 96	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME OLIVER C FAZENBAKER		
14. MOTHER'S MAIDEN NAME NANCY SILGER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW1		
16. SOCIAL SECURITY NO. 217 09 9275		17. INFORMANT CATON BALTO MD 21226 ST AGNES HOSP RECORDS WILKENS &		
18. 412.4 + 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Congestive Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arturoschertic Cardiovascular Diseases years (B) Carcinoma of the Lung Unknown		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 14 1968 to 9 17 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9 17 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. Braulio Franco		23B. DATE SIGNED 09 17 68		23C. PHYSICIAN'S NAME (Type) DR. BRAULIO FRANCO
23D. ADDRESS ST AGNES HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-20-68	24C. NAME OF CEMETERY or CREMATORY Cedar Hill	24D. LOCATION (City, town, or county) (State) Anne Arundel Cty, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968	25B. NAME OF REGISTRAR Robert E. Tabor, MA	25C. FUNERAL DIRECTOR 650. L. Schwab, FUNERAL HOME Francis W. Miller 2101 Frederick Ave.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-9498	
BIRTH NO. B-252				68-9498	
1. NAME OF DECEASED (CORALIE BUCKINGHAM) Type or Print Cora Buckingham				2. DATE AND HOUR OF DEATH 9-15-68 6:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-12	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4940 EASTERN AVE. 21224					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-89	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME JOHN FOSS			14. MOTHER'S MAIDEN NAME MARY Rogers		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no --- 216-07-1310			16. SOCIAL SECURITY NO. 216-07-1310		
17. INFORMANT RECORDS: BCH: 4940 EASTERN AVE. BALTO., MD. 21224			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Unknown					
(B) Flacid tetraplegia DUE TO, OR AS A CONSEQUENCE OF:					
(C) No celebration					
33-2X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cardiac A-V block					
19A. DATE OF OPERATION 3-7-6-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Required Respiration		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---	
22. I certify that (I) (this hospital) attended the deceased from 9-1 1968 to 9-15 1968, that (I) (we) last saw the deceased alive on 9-14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald G. Michels M.D.				23B. DATE SIGNED 9-15-68	
23C. PHYSICIAN'S NAME (Type) RONALD G. MICHELS M.D. Ronald G. Michels M.D.				23D. ADDRESS 4940 EASTERN AVE. BALTO., MD. 21224 Baltimore City Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/19/68		24C. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR H. Sander & Sons, Inc., Balto., Md.	

Unknown

Flora tetralopis

(Caroline A. L. Clark)

7-6-88 isopropyl alcohol

NO

8-12-88

88

88

8-14-88

8-12-88

x

Ronald G. Michaels MD

Baltimore City Hospital

Ronald G. Michaels MD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) CALVIN JONES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour September 12, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2129 Lyndhurst Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour September 12, 1968 10:45 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 00		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 65		E. STREET AND NUMBER 2129 Lyndhurst Avenue	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Wilson		18. ADDRESS 1310 Edgewood Rd	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED September 12, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-68	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1968		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Furnell B. [unclear]		25D. ADDRESS 1735 Harford Ave. 21213	

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

1933-34

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 9500

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FANNIE BAMSTEAD

2. DATE
OF DEATHKnown ☐ Month Day Year Hour
Estimated ☐ September 17, 1968 2:37 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Hopkins Hospital

3. DATE
PRONOUNCED DEAD Month Day Year Hour
September 17, 1968 2:37 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Pennsylvania B. COUNTY V-35

6. SEX
Female7. RACE
Negro8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐C. CITY OR TOWN
Media

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

5/27/05

10. AGE (In years
last birthday) 63If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

410 N. Olive Street

11. BIRTHPLACE (State or foreign country)

Wilcoe W. Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Lewis Brown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BEAUTICIAN

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Polly Harper

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

409-30-0546

18. INFORMANT

MARY Kinslough 410 N. Olive Media PA.

ADDRESS

19. E 812.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Acute Peritonitis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Rupture of Cecum

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Bronchopneumonia and Pyelonephritis

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

U.S. Rte. 40 130' East of Chesaco Avenues

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) Sept. 11, 1968 12:15 P.M.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Driver in auto-auto collision

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 17, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/21/68

24C. NAME OF CEMETERY or CREMATORY

Calvary Cem.

24D. LOCATION (City, town, or county)

Media Delco PA.

25A. DATE REC'D BY HEALTH DEPT.

SEP 18 1968

25B. NAME OF REGISTRAR

Robert E. [Signature]

25C. FUNERAL DIRECTOR

David S. Pinkston 17 W 3rd St Media PA.

ADDRESS

WALLING FROM 0100
01/01/01 01/01/01